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ABSTRACT

This document reports on a 2-year study to determine the health education needs of young people in Scotland and to collaborate with teachers to improve the delivery of health education in relation to specific issues. The study was in two phases. Phase 1 assessed the needs of pupils according to the views of the pupils and adults, their needs based on local problems and the differences between urban and rural schools; communication between school and home regarding students' health, opportunities for involving parents in student affairs, parental satisfaction with their involvement, and the schools' perspective regarding parental involvement; joint responsibility for health education, including the most appropriate place for discussion of related subjects and where pupils can go for information; parents' and pupils' perceptions about discussions of health matters at home; the school's contribution to health education from the perspective of parents and students; and the views of students, teachers, and parents on the schools' commitment to the promotion of good health. Phase 2, which concerned two pairs of associated schools, covered staff workshops on health education; reactions to the findings of Phase 1 on the different perspectives regarding health education; issues for discussion; and implications and recommendations. Three appendices provide the questionnaires and tables of health promoting activities (both primary and secondary), and social education syllabus (secondary). (Contains 11 references.) (CK)

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Exploring the Health Education Needs of Young People

Marion Devine
Jacqueline Mapp

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Exploring the Health Education Needs of Young People

Marion Devine
Jacqueline Mapp

The Scottish Council for Research in Education

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Marion Devine
Jacqueline Mapp
April 1996

Executive summary

This is the report of a two year project which began in October 1993 and was funded by the Scottish Office Education and Industry Department (SOEID).

Aims of the project

- to determine the health education needs of young people
- to collaborate with teachers to improve the delivery of health education and promotion in relation to specific issues arising from the first phase.

Methodology

This was a two year study in two phases. In **Phase 1** information was gathered from 8 pairs of associated schools (primary and secondary) by semi-structured interviews with pupils, parents, teachers and health professionals and by questionnaires to pupils, parents and teachers. The information gathered, related to the health education needs of pupils at P4, P7, S2, S4 and S6 and the extent to which these needs were being met.

In **Phase 2,** in the second year of the study, two pairs of associated schools, one urban and one rural, were involved. Staff in each school were presented with the findings from their own school from Phase 1 as a basis on which to review and improve their health education programme. Semi-structured interviews were held with members of the senior management teams, teachers and pupils. Questionnaires were also completed by teachers and pupils. Factors which contributed to or hindered development were noted throughout the year.

PHASE 1

The needs of pupils

1.1. There was a considerable degree of consensus about the needs of pupils from parents, teachers, health professionals and young people themselves. The main priorities for young pupils (age 8) were healthy eating, personal hygiene, drugs education, smoking, exercise and safety.

1.2 For pupils age 11 and over the priorities were drugs education, sex education, HIV/AIDS, alcohol and smoking.

Communication between school and home

2.1. In secondary schools, the most frequently used form of communication was school newsletters, in the primary schools it was letters to parents.

2.2. When schools did seek the views of parents it was usually on controversial issues such as sex education and drugs education.

2.3. About one third of parents in both sectors would like to be more involved. In most cases they simply wanted to know more about the health education curriculum.

Joint responsibility

3.1 Three quarters of all parents thought that most aspects of health education were the joint responsibility of the home and the school. The exceptions were personal hygiene and family relationships. These were thought to be the responsibility of the home.

Discussions in the home

4.1 Less than half of parents of both primary and secondary pupils said that they discussed sex education and HIV/AIDS at home. This view was corroborated by pupils.

The contribution of the school

5.1 Most pupils in primary schools said they discussed getting on with friends, healthy eating, personal hygiene, exercise and safety. Over 80% of P7 pupils said that sex education, HIV/AIDS and drugs education were rarely or never discussed. One third of P7 pupils never discussed smoking in class.

5.2 In secondary schools, more than one half of all pupils at S2, S4 and S6 said they rarely or never discussed drugs, sex education, alcohol or smoking in class. HIV/AIDS was discussed by the majority of S4 pupils.

5.3 The majority of older secondary pupils noted that methods used in health education classes differed from those used in subject classes. There was more discussion, an element of choice and the classes were more relaxed and informal. Fewer primary pupils and pupils in S2 noticed any difference.

Health promotion

6.1 Primary pupils were significantly more positive than secondary pupils about health promoting aspects of school. They were more likely to say that health was important in their school, that the environment was safe and pleasant, there was a good selection of foods, good links with parents and that staff and pupils respected each other.

6.2 The importance of school ethos and a caring environment were highlighted by both primary and secondary staff as significant aspects of health promotion.

6.3 Those parents who were interviewed were supportive of the idea that the school had a role to play beyond that of the formal curriculum.

PHASE 2

Preparing for action

8.1 Presentations and discussion points were prepared for the two pairs of associated schools taking part in Phase 2. Information was provided on the priorities for young people drawn from a number of different research, research findings related to some of these priorities, different approaches to health education and to evaluations of these approaches.

8.2 Staff in schools were also presented with a summary of the findings from Phase 1 as they related to their own schools.

Reactions to the findings

9.1 Schools faced more of a challenge in meeting the needs of P4 pupils than any other groups. For this age group there were differences between the needs as identified by pupils and parents and those identified by teachers.

9.2 The primary schools were at different stages of development in relation to health education and reacted differently to the findings. One school selected a resource around which to structure the health education curriculum and made several changes in the course of the year to meet the needs of pupils. The other school, due to a number of external and internal constraints, used the year of the project to collect resources and plan for changes in the future.

9.3 There were very few differences in the areas selected as priorities for secondary pupils. Pupils at S4 appeared to have most reason to be satisfied as both they and their social education teachers agreed that their major priorities were included in the health education programme.

9.4 Areas where needs were not being met included drugs education for the youngest group of pupils, sex education for some P7 pupils and HIV / AIDS for younger secondary pupils. In most cases schools already had plans to include these needs in future.

9.5 A number of constraints were identified which made it difficult for schools to meet the needs of their pupils within the time scale of the project.

Health education matters

10.1 In all schools, senior management met to discuss a number of whole school issues likely to be of interest to schools generally.

The content of the health curriculum

10.2 Teachers felt that they had the main responsibility for deciding what to include in the health education curriculum. Local and national guidance could be used to help. They also recognised that parents had to be consulted and informed.

10.3 Even where schools included topics identified as needs, secondary pupils did not always get the knowledge they were seeking. Nor did they necessarily link such activities as decision making and building self esteem as anything to do with drugs or sex education.

Coping with sensitive issues

10.4 Senior staff suggested a range of ways of coping if a teacher felt uncomfortable with any aspects of health education.

10.5 The primary schools had problems in deciding how much sex education to include and when to start.

The role of outside agencies

10.6 Schools stressed the need for health education to take place in a climate of trust and good relationships between staff and pupils. They felt that it was difficult for outside agencies to build this relationship. They welcomed the support of outside agencies to help teachers develop appropriate skills, extend their knowledge and keep up with the latest developments.

Implications and recommendations

11.1 Funders of research, researchers and staff in schools involved in research must be realistic about the time needed to plan and implement curricular change.

11.2 ***Recommendations for senior staff***

- The school's handbook to parents should stress the breadth of the health education curriculum and include more information for each year.
- Schools should take advantage of the guidance available from local authority resources to help them in discussions with parents on issues which might be controversial or sensitive.
- Staff in primary schools should involve parents in a discussion on recent guidance on drugs education.
- All schools should canvass the views of pupils and parents on issues which are recognised to be the joint responsibility of the school and the home.
- Where there is a difference between teachers' views and parents' views staff must explain their position to parents.
- Schools should develop a set of criteria which can be used to set the standards for effective planned partnerships with local support agencies.
- Visits to classes from external agencies should be evaluated to determine the extent to which they meet pupils' expectations and the visitors' intentions.

11.3 ***Recommendations for teachers***

- A core and option model of health education should be considered for all years which would allow an element of choice for pupils
- Teachers should try to ascertain what their pupils already know and what they would like to know.
- Teachers should invite a group of pupils in each class to review their perceptions of the health education programme in terms of its content and teaching approach.
- Teachers must tell pupils why they are taking part in certain activities and how these activities relate to other aspects of the curriculum.

11.4 ***Recommendations for local authorities***

- Local or national bodies such as health promotion units, HEBS or the SCCC should provide a regularly updated catalogue of existing resources for the use of schools. The content and the teaching approaches used should be included.
- Lengthy policy and guidance documents should include separate executive summaries referenced to pages in the full report.
- Local authorities should compile a register of local agencies involved in health education which teachers could turn to for independent information.

1 Introduction

In 1993 the Scottish Council for Research in Education carried out a survey of health education in Scottish schools. One of the findings of the report of this survey highlighted the importance of identifying the health education needs of pupils (Devine, Black and Gray, 1993). As a result, the Scottish Office Education Department initiated a more detailed study of health education and health promotion. The study was carried out in two phases: first, to determine the health education needs of young people in primary and secondary schools and second, to collaborate with teachers to improve the delivery of health education and health promotion in relation to specific issues arising from the first phase. This report is based on the work of both phases. Information is presented from pupils, parents, teachers and health professionals on the needs of young people gathered during the first phase of the study. How a small number of schools reacted to this information in the second phase is also included. The report concludes with a discussion of the issues which arose during the study and highlights some of the implications for teachers, school management and local authorities.

■ Choice of schools

For the first phase of the study, eight pairs of associated schools were chosen from five regions across Scotland. The schools included urban and rural schools, denominational and non denominational schools and schools in areas with particular health problems. Table 1.1 shows the number of urban/rural schools involved in the study. The total number of pupils who provided information is given in brackets.

Table 1.1 Schools involved

	Urban	Rural
Primary	4 (175 pupils)	4 (167 pupils)
Secondary	5 (263 pupils)	3 (204 pupils)

In the second phase only two pairs of associated schools were selected to satisfy a number of criteria. The selected schools

- were drawn from the eight pairs of schools studied in Phase 1
- identified health education as a priority
- were interested in taking part in the project
- represented different locations (ie urban and rural)

These four schools included one pair of schools from an urban area where there was a recognised high level of drug misuse and one pair from a rural area where the primary and secondary schools were on the same site and under the same senior management team.

Gathering information

In both phases of the study, information was collected by semi-structured interview and by questionnaire. The semi-structured interviews were constructed to allow each group of respondents to put forward their own views on health education including their opinions on the needs of young people of different age groups. Results from these interviews and the findings from the earlier survey were used to prepare questionnaires for larger groups of respondents. Interviews were held with small groups of pupils from P4, P7, S2, S4 and S6; with teachers of P4 and P7 children and key members of staff involved with health education in the secondary schools; with headteachers and members of the senior management teams. In the first phase, parent members of the school board were also interviewed as were health professionals connected with the schools. The health professionals included health education/promotion officers, school nurses, school doctors, health visitors and/or local GPs.

With the youngest groups of pupils, ie those at P4, the discussions during the interviews were stimulated by the use of brightly coloured pictures related to a range of health topics which the pupils were asked to match to pictures of two children. One child looked bright eyed and happy, representing 'the healthy child', the other looked thoroughly downcast, representing 'the unhealthy child'. Discussions centred around why each picture had been selected. The same cards were used to ask pupils if they had ever discussed something like this at home or in the school. Pupils were also asked to choose cards which showed the topics they thought it was really important for children of their age to know about. Interviews with older pupils, parents, staff and health professionals were structured to allow a free exchange of what mattered in health education before going on to discuss selected areas of health. The selected areas based on the findings from the 1993 survey were printed as follows:

Alcohol
Drugs education
Environmental health (eg litter, vandalism)
Exercise
First aid
Healthy eating
HIV/AIDS
Personal hygiene
Relationships with family
Relationships with friends (including bullying)
Safety
Sex education
Smoking

In both phases, questionnaires were completed by pupils at P4, P7, S2, S4 and S6. In Phase 1, parents of these pupils, principal subject teachers in the secondary schools and recent school leavers from each of the secondary schools were also invited to complete questionnaires. In Phase 2, questionnaires were completed by

teachers in the primary schools and by principal subject teachers and social education teachers in the secondary schools. Table 1.2 summarises how and from whom the information was gathered in each phase.

Table 1.2 Summary of information gathered

	Phase 1 (8 pairs of schools)		Phase 2 (2 pairs of schools)	
	Questionnaire	Discussion	Questionnaire	Discussion
Primary pupils	P4/P7	P4/P7	P4/P7	P4/P7
Primary teachers		P4/P7	All	P4/P7
Secondary pupils	S2/S4/S6	S2/S4/S6	S1 - S6	S1-S6
Secondary teachers	PT(subject)	Key staff involved with health education	PT(subject) PSE/Guidance	PSE/Guidance
Senior Management Teams		√		√
Parents	Of pupils at P4/P7 S2/S4/S6	School Board members		
Health professionals		√		
School leavers	√			

The structure of the report

The findings from both Phase 1 and Phase 2 of the project are presented in this report. Chapters two to seven are based on the work of Phase 1 and present the needs of young people and the extent to which the home and the school contribute towards meeting these needs and to health education generally. Chapters eight to ten are drawn from Phase 2 of the project and report on how two pairs of associated schools reacted to the findings from Phase 1. The final chapter summarises the major issues arising from the project as a whole and considers some of the implications for teachers, school management and local authorities.

2 The needs of pupils

We address drugs because they are high profile but I feel we miss out on other needs.
(secondary teacher)

I am sure they have needs which are greater than we're providing for.
(primary teacher)

Findings from an earlier survey on Health Education in Scotland (Devine, Black and Gray, 1993) show that the majority of teachers believed that they were meeting the needs of young people in their health education programmes. Whether this view was shared by the young people was clearly an important area to explore and in the first phase of this study young people between the ages of 8 and 17 were invited to say what they thought they needed from health education. Parents, health professionals and teachers also have a legitimate interest in expressing their opinions about the needs of young people and they too were asked to contribute to the debate. Apart from the very youngest group of pupils there was a considerable degree of consensus from all groups about the health education priorities for young people.

■ Pupils' own views

Pupils' views were sought both by interview and by questionnaire. Groups of pupils from P4, P7, S2, S4 and S6 were asked to discuss their health needs and to say what they thought were the priorities for people of their age. Similar questions were asked in the questionnaires. Table 2.1 shows those health-related areas which were selected by more than one quarter of school pupils.

Table 2.1 Pupils' own priorities (%)

Health area	P4 n=169	Health area	P7 n=173	S2 n=176	S4 n=169	S6 n=122
Healthy eating	46	Drugs education	65	81	75	82
Drugs education	42	HIV/AIDS	30	49	58	70
Smoking	39	Sex education	35	44	57	52
Hygiene	29	Alcohol		25	25	27
First Aid	26	Smoking	40	37		
Exercise	25	Safety	25			

Pupils from P7 to S6 held very similar views on what they needed from health education and in response to a similar questionnaire the first three areas (drugs education, HIV/AIDS and sex education) were also suggested as priorities by young people who had recently left school. The younger pupils included smoking and P7 pupils also thought that safety was important. The list of priorities from P4 pupils differed to some extent from those of older pupils although they also included drugs education and smoking.

Pupils and recent school leavers were asked to suggest any other health-related areas which should be included in health education. Only small numbers responded and areas mentioned by individuals from both groups were solvent misuse, sexually transmitted diseases and child abuse.

Given that all ages from P7 onwards both in questionnaires and in interviews selected more or less the same areas as priorities, there are bound to be some problems with repetition or timing:

> *They tell you something in Primary 7 and the same thing in S1.*
>
> *They tell you how many units of alcohol make you over the limit when you are not even old enough to drive yet.*

On the other hand there was recognition that some repetition was necessary:

> *AIDS? I don't think you could hear too much of it ...if you're constantly reminded you're constantly aware.*

When pupils were asked in interviews if they thought there was too little or too much emphasis on any areas, pupils from eleven of the sixteen schools, mentioned first aid as one on which they would have welcomed greater emphasis. This choice was confirmed by recent school leavers who most frequently identified drugs education and first aid as topics on which they would have liked more information while at school.

■ Adults' views on the needs of young people

For primary pupils

The pupils' own selection of important areas for health education was mostly confirmed by other groups. Teachers, parents and health professionals agreed that healthy eating, personal hygiene and exercise were major priorities for P4 pupils. Rest and sleep were specifically included as priorities by teachers and health professionals. Parents as well as pupils but not teachers or health professionals mentioned the importance of drugs education. Safety was a concern of parents and teachers. During interviews aspects of safety raised by parents were limited to physical dangers such as roads, railways and canals or rivers rather than personal or emotional dangers which were included by teachers.

For pupils at P7, parents, teachers and health professionals all agreed with pupils that drugs education, sex education and smoking were priorities. Again health professionals were more specific by stressing puberty as the focus for sex education. Healthy eating was high on the agenda for parents, teachers and health professionals. Teachers were the only group who highlighted relationships as a priority for primary pupils. None of the adult groups included HIV/AIDS in their list of priorities for this age group.

For secondary pupils

For secondary pupils, the most striking similarities were among the priorities of pupils themselves and their parents. The same four areas were chosen by both groups - drugs education, HIV/AIDS, sex education and alcohol education. Health professionals also stressed HIV/AIDS for the two older groups and sex education for S4 but at S6 they were more specific in suggesting discussions on

pregnancy and parenting skills. Both teachers and health professionals also identified some aspect of emotional health as a priority for pupils at S2.

A few individual parents put forward suggestions for additional areas to be included in health education and these included stress, bereavement, disease and illness, decision making and self defence.

Teachers generally provided longer lists of priorities which overlapped with those suggested by pupils. For S2, teachers included with the pupils' own priorities, healthy eating, exercise and relationships. The additional areas at S4 were smoking, exercise and relationships. Smoking and healthy eating were also included for S6 pupils but sex education, which was prioritised by the pupils, was not. This omission may be because teachers think that by S6 there is no longer any need to include sex education in the health education curriculum. However, the comment of one S6 pupil suggests one possible reason why it still appears in the pupils' own list of priorities.

> *When you're younger, sex education isn't so relevant. It's just a laugh. It's not until you get into S5 and S6 that you start thinking about it and want to ask questions.*

Needs based on local problems

During discussions with health professionals, they were asked if there were any local problems which might make certain issues more important for schools in these areas. Among problems highlighted were local drug problems particularly where there were parent users and where signs relating to injected drugs were part of the every day experience of the children. Teenage pregnancies were also mentioned and alcohol was cited where there was perceived to be a local culture based on drinking. Poor diet related to a high level of coronary disease and poor dental hygiene were also mentioned in specific areas. Parents were also asked if they were aware of any particular health problems in the area and in almost every area at least one parent mentioned a problem with drugs. This was not always corroborated by evidence from health professionals in the same district and may reflect parental concern related to media coverage rather than local reality.

Where there were serious drug problems, most schools in these areas were already well aware of local problems and their health education programmes reflected these concerns.

> *Children here know the evils of taking drugs. We're just trying to build up their personal skills to make decisions themselves and work out their responses to a situation before it happens.*
>
> P7 teacher

Differences between urban and rural schools

When planning the first phase of the study and selecting the schools to take part, it was considered to be likely that the needs of pupils might differ depending on locality and socio-economic status. However, although certain areas had more problems than others in relation to health matters such as drugs, there were no differences between the needs of pupils as perceived by pupils or their parents. This lack of differentiation on the basis of local needs may be due to the influence of the media which focuses on high profile health matters such as drugs and HIV/AIDS and these matters are therefore viewed as either real or potential problems which have to be included in every school health education curriculum.

3 Communication between school and home

Parents could be more informed very briefly about things children will do as regards health. I think people would be happy with a rough outline.

The knowledge and beliefs developed by young people about health will have an impact on their future lifestyle and possibly, on the lifestyles of their families and of the next generation. In health education, more than in many other areas of the curriculum, the school is only one of a number of influences which include their family, friends and the media. If the school and the home are to collaborate in providing the best for young people then good communication links are important to ensure that the needs of young people are being met either in school or at home. Parents were asked to comment on how the school communicated with them and how satisfied they were with their opportunities to be involved in health education.

Parents' opinions were sought in two ways. We spoke to parent members of the school board in each of the schools visited and questionnaires were sent, by pupil post, to the parents of each of the pupils involved in the study. A total of 342 primary pupils and 467 secondary pupils completed questionnaires and were given questionnaires to take to their parents. Only 131 questionnaires (38%) were returned by primary parents of which 52 were from parents with children at urban schools and 79 were from rural parents. 183 secondary parents (39%) returned questionnaires and of those 107 were from urban parents and 76 were from rural parents. The low response rates must be taken into consideration when interpreting the results from parents.

Ways of communicating with parents

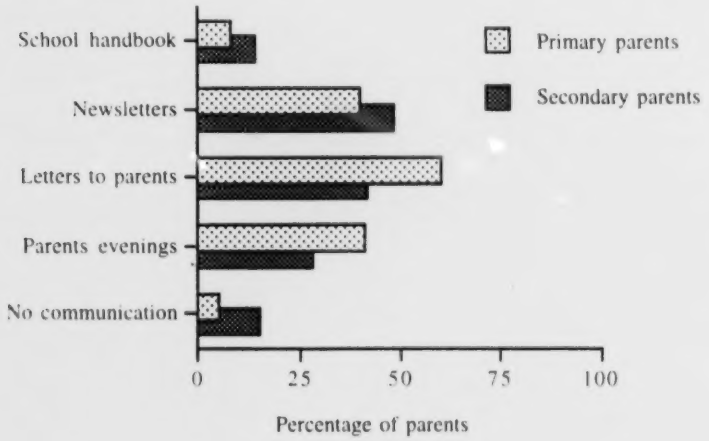
The school has frequent parents' nights. Health is one [topic] where parents would be expected to have an input.

It could be argued that health education, more than many other areas with which the school is concerned, is the joint responsibility of the school and the home. For health education to be effective, parents and schools must share the same values and encourage similar health promoting practices. It is, therefore, important that there is continuing communication between school and home and that parents feel that they have some input into an area of education which may set the habits of a lifetime.

We asked parents how the school communicated with them about matters of health education and what opportunities they were given to be involved. Figure 3.1 shows that letters to parents were the most common form of communication for primary parents and newsletters for secondary parents. Primary parents were significantly more likely than secondary parents to indicate that communication consisted of letters home and parents' evenings. Not surprisingly, parents in

urban schools where the population was less scattered were more likely to be invited to parents' evenings than parents in rural schools.

Figure 3.1 How the school communicates with parents about health matters



Letters and newsletters are usually sent by 'pupil post' and during our discussions with parent members of the school boards more than one parent mentioned difficulties with this method of communication while recognising that the cost of individual postage was prohibitive:

> *The danger of school newsletters and even letters and school reports is that they become paper maché at the bottom of school bags.*
>
> primary parent

> *As children get older and more discriminating they may choose what gets home.*
>
> secondary parent

The urban/rural difference between the holding of parents' evenings was explained at least in part by one of the parent members of the school board of a rural school. Here there were good reasons why parents' evenings were not an ideal means of communication:

> *One of the big difficulties is the school has such a large catchment area. If we focused on meetings it could lead to a [town] cabal and we did not want that.*
>
> secondary parent

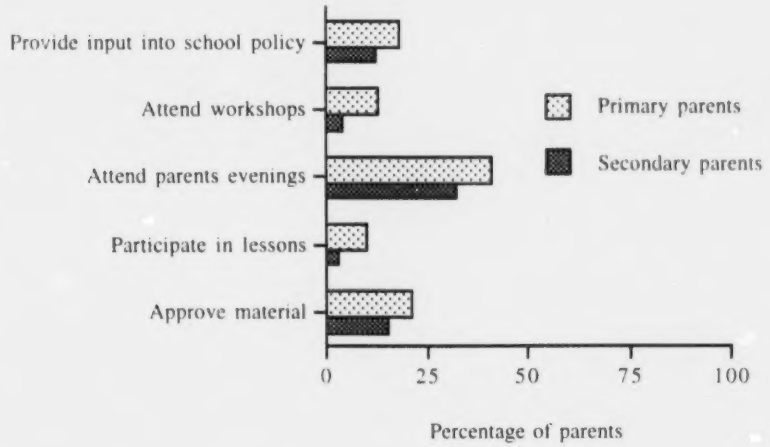
Opportunities for involving parents

> *They were doing open nights for Feeling Yes, Feeling No. They go through phases of 'campaigns' which is probably the best way to explain it. Healthy Eating was one where we were sent home things suggesting what kids could have in their play piece.*

Communication with parents can of course be a one-way process with the school acting as the provider of information to the parents. We were also interested in the extent to which opportunities were provided for parents to interact with and

complement the work of the schools. Figure 3.2 shows the percentage of parents who reported that any such opportunities were provided. Individual parents mentioned a few additional means such as special health events, school trips and the open door policy.

Figure 3.2 Opportunities for parents to be involved



When schools did seek parents' views on health education, it was usually because the topics were controversial such as sex education and drugs education:

> *The school did a consultation exercise when they were going to use Living and Growing. Parents were told that the children were going to be shown these programmes and were given the opportunity to object if they so desired. They were also given the opportunity to see the material.*
>
> primary parent

> *The primary 7 teachers had the parents in; there was a video on drug abuse. They're trying to introduce it into the school.*
>
> primary parent

In at least two of the schools visited, outside speakers were invited to talk to parents about these issues. Sometimes parents themselves had relevant professional expertise which was shared with other parents at parents' evenings or special events.

In discussions with parents from both the primary and the secondary sector, many mentioned the open door policy of the school which meant that if any parent was concerned about any aspect of education including health education they were free to approach the school and discuss matters or, sometimes, to sit in with classes to observe lessons:

> *Parents are made very welcome to come into the class at any time. If a parent felt they wanted to be there at the time of the sex education class they can be there.*
>
> primary parent

Differences between parents

Generally, more primary than secondary parents were aware of a range of opportunities and urban parents were more likely than rural parents to be invited to attend workshops or approve material. Parents of pupils in schools with a high percentage of free school meal entitlement were also more likely to report opportunities for attending workshops, participating in lessons and approving materials.

Parental satisfaction with their present involvement

The school operates an open door policy to the Rector or the Depute Rector with regard to any problems. That's indicated in letters home. If your children are experiencing any difficulties of any kind please get in touch and it will be discussed confidentially. Nobody's turned away and everybody's listened to.

secondary parent

Parents were also asked whether they were happy with the present level of involvement and, if not, to suggest ways to improve the situation. 50% of the parents were happy with the present level of involvement and less than 20% were unsure. About one third of both sets of parents would like to be more involved. Suggestions made by at least 10% of parents who responded are shown in Table 3.1

Table 3.1 Parents' suggestions for further involvement

Suggestions	Primary parents (n = 37)	Suggestions	Secondary parents (n=48)
Would like to know more	49%	Would like to know more	59%
Participate in lessons	16%	More newsletters	10%
Approve materials	16%	Approve materials	10%
Follow up class work	16%	Follow up classwork	10%
Workshops for parents	14%	Opportunities to comment	10%
More newsletters	11%		
More parent evenings	11%		

By far the largest percentage would be happy simply to be kept informed of what was happening in health education:

I believe the school covers certain aspects of health education very well such as exercise and sex education but I don't know how well they cover all other aspects.

secondary parent

Perhaps reflecting the problems of communication reported by rural schools, parents in urban areas were more likely to be happy with the present level of involvement than parents in rural areas.

Many schools do provide the opportunity for parents to approve materials which they think are likely to be controversial. Whether parents would either want or have the time to approve other materials is doubtful:

Parents are busy people and I think they are happy to leave things to teachers.

primary parent

I have no concerns about putting my complete trust in the staff.

secondary parent

Several parent members of the school boards referred to their own efforts to encourage parental involvement and reported that responses were often disappointing.

The schools' perspective

Teachers were asked about the extent to which parents were involved in health education. Some teachers in both sectors said that parents were not involved as much as they could be and thought that there were deficiencies on both sides:

Parents are not well informed by us.

I don't think I've ever come across a parent who has asked to be involved or shown any interest.

Other teachers provided a number of examples of ways in which parents were involved. In some primary schools, parents were invited in to school to talk about relevant topics and help out with school sports and clubs. One school had a family support base which parents attended and another held formal parents' evenings which were specifically focused on health and which provided parents with the opportunity to influence policy in this area. Secondary school teachers mentioned newsletters, information evenings and sporting activities. One school had a health committee which involved parents and another held a health awareness week in which parents were invited to join. Both sets of teachers mentioned the PTA and the school board as other means of involving parents:

The school board ran a session on the drugs issue which was very well attended.

Whose responsibility is it?

Communications on health education from the school are one way of encouraging teachers and parents to work together and to share responsibility:

If the school gave parents a leaflet to show what it is going to cover before the start of the term, that would be a good idea so that parents could be involved at home.

A fuller discussion of the nature of the joint responsibility between parents and schools is presented in the next chapter.

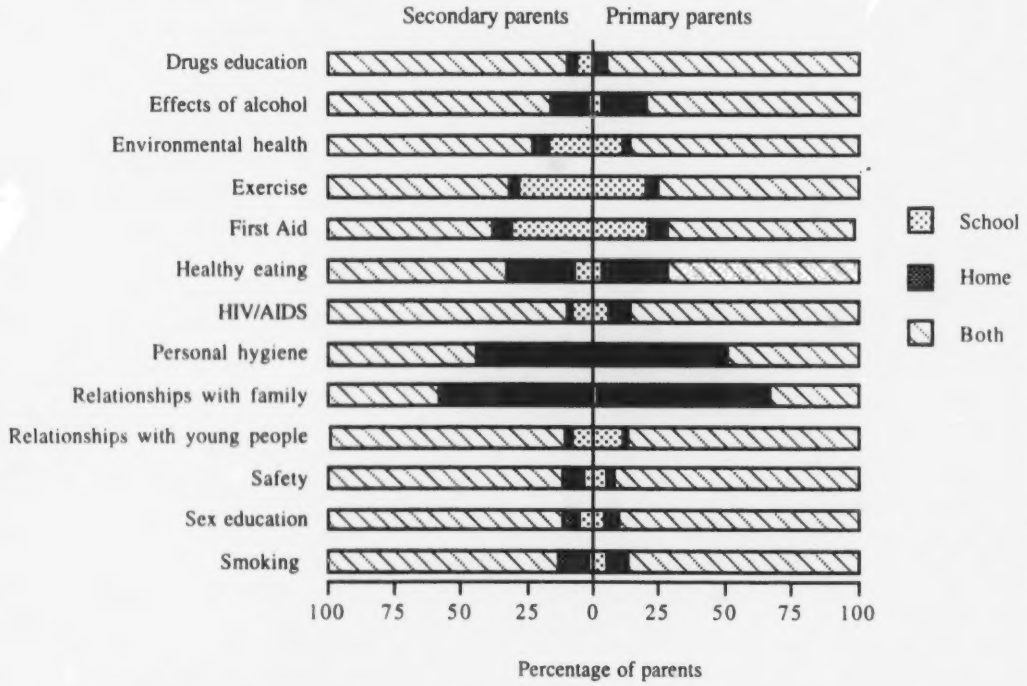
4 Joint responsibility for health education

It should be a joint effort with in some cases the home reinforcing what the school is trying to do.

The most appropriate place to discuss health education

The majority of parents accepted that both the school and the home have a responsibility for most aspects of health education. Figure 4.1 illustrates the opinions of both primary and secondary parents on the most appropriate place to discuss health matters.

Figure 4.1 The most appropriate place to discuss health matters



Even those parents who believed strongly that they had the prime responsibility for certain areas recognised the need for the school to be involved:

School should provide a safety net. If the school were to miss topics some children would never discuss them.

primary parent

Other parents took the view that there are certain areas where parents have insufficient knowledge to do justice to a topic and welcomed informed professional input:

Let's be honest. I don't know the half of it. How can I talk to them about drugs?

primary parent

Parents often have misconceptions about first aid if they have not had any proper training. Even simple things like what to do with a nose bleed.

secondary parent

Only the topic of 'relationships within the family' was said by the majority of all parents to be most appropriately discussed at home. However, during discussions with parents, several thought that there were advantages for family issues being aired in an impersonal and general way in schools. There was also some support for tackling changing patterns of contemporary family life:

At home you're involved in the relationship so it's hard to step outside. To get a degree of objectivity it's probably better done through the school. They can discuss issues without getting emotional.

primary parent

Relationships within the family should be covered in the family but different members have different perspectives. It is a worry for kids when they hear of other parents splitting up. You could do with education on how to cope with parents who have split up and how the children should cope.

secondary parent

There was recognition that in some areas, the messages from school and home might differ and that, for example, this might include the problem of bullying:

The school might take a less confrontational attitude than the parents.

primary parent

One or two individual parents raised concerns that sometimes sensitive issues were being discussed when they would prefer that they were not:

Sometimes my wife wishes there was some way she could go and say 'I don't want my children doing that I'd rather they went to the library and did some studying.'

secondary parent

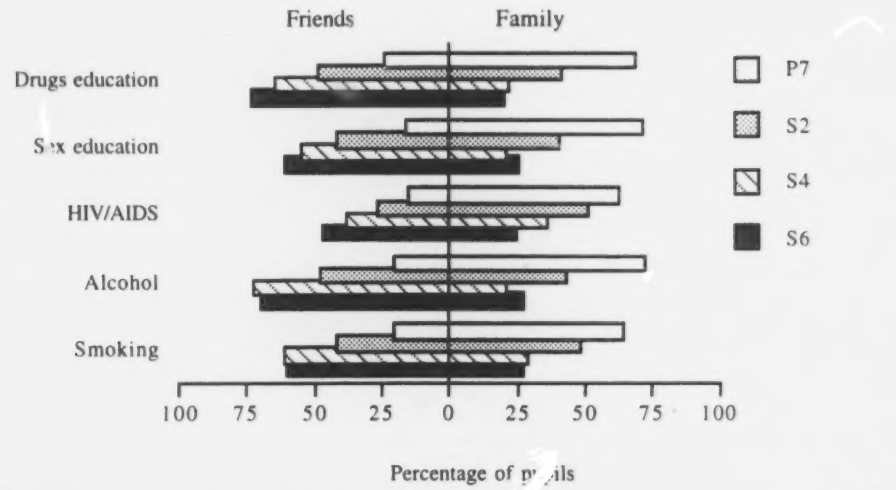
■ Where do pupils go for information and advice?

Pupils were also asked to indicate the first person (or group) they would speak to if they needed advice or information about any health related areas. All pupils were asked this question in the face to face discussions, with the older pupils (P7 - S6) responding to the same question in their questionnaires.

The youngest pupils were more or less unanimous in naming some member of the family as the person whom they would consult. However, they were mostly also aware that certain telephone helplines had been set up and mentioned these as places where you could get help for smoking and for bullying.

Figure 4.2 (overleaf) shows the results from the questionnaire for those areas which were identified as priorities by pupils from P7 to S6.

Figure 4.2 Who do young people turn to for advice?



The younger pupils mostly turn to the family as the source of assistance while the older pupils turn to friends. This is in line with previous research by the Scottish Health Behaviour of Scottish School Children survey (Currie, Todd, Wijckmans, 1993) which found that young people are increasingly likely as they grow older to talk to their friends about things that are worrying them. Small numbers of pupils at S4 and S6 suggested other agencies whom they would turn to for advice. These included the medical profession and organisations such as the Red Cross, Alcoholics Anonymous and the Family Planning Association. Various telephone helplines were also mentioned.

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5 Discussions in the home

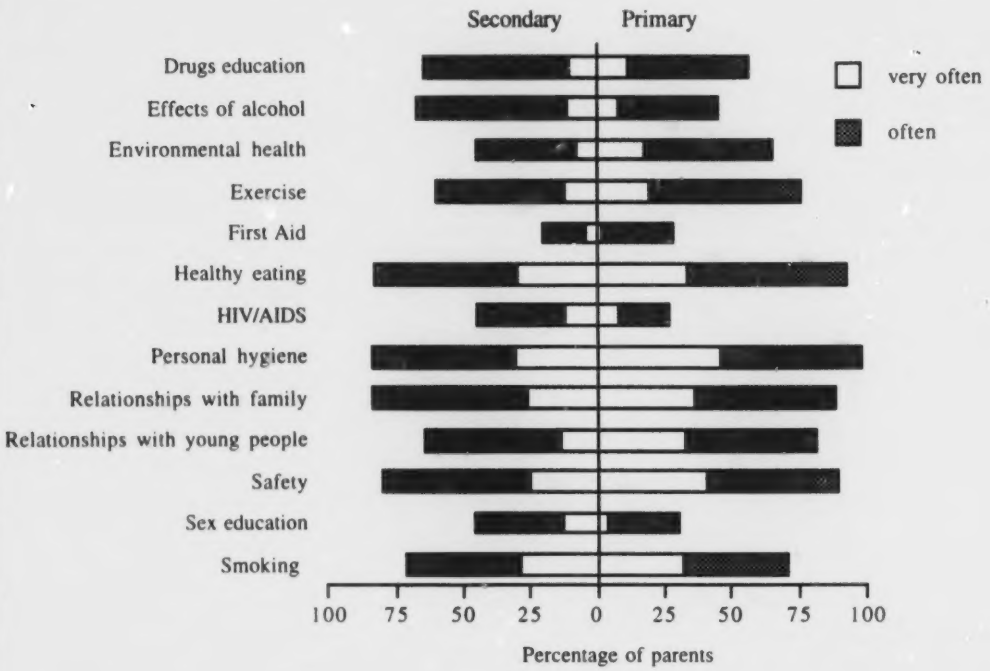
In the house my wife and I have always been very open and willing to discuss anything the children wanted to talk about. The amount of health education they get at school tends to be not of great importance. Usually it's something they already know about.

It's all right saying leave it to the home. A lot of parents could do it and very well but I would say 90–95% of them don't.

Parents' perceptions

From previous research (Connell, 1986) we know that health education is more likely to be effective if parents are prepared to discuss the various issues with their children. The majority of parents in this study supported the view that the school and the home should both be responsible for health matters. Figure 5.1 indicates how often parents say they discussed certain topics with their children. Clearly some of these topics are more relevant to older pupils and, for example, HIV/AIDS was rarely discussed by the majority of parents of primary children.

Figure 5.1 Parents' perceptions of topics discussed at home



When statistical differences between the two sets of parents were considered, primary parents were more likely to say they discuss environmental health (e.g. vandalism and litter), exercise, personal hygiene, relationships with other young

people and safety. Secondary parents were more likely to say they discuss effects of alcohol, HIV/AIDS and sex education. To a large extent these differences tend to reflect the priorities identified by parents for young people. More than three quarters of all parents said they often discussed:

- healthy eating
- personal hygiene
- relationships with the family
- safety.

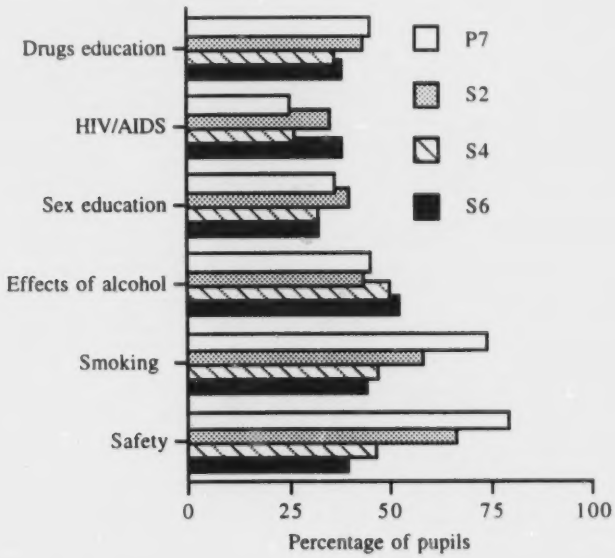
There were also some significant differences between parents in urban and rural areas. Parents in urban areas were more likely to say they discuss drugs education, HIV/AIDS, personal hygiene and smoking than parents in rural areas.

At secondary level, topics which parents themselves identified as priorities included drugs education, HIV/AIDS, sex education alcohol and smoking. Of these, according to more than half of the parents questioned, sex education and HIV/AIDS, are topics not often discussed at home. Parents of P7 children identified drugs education, sex education, healthy eating and personal hygiene as priorities and in this case sex education was again a topic which tended to be neglected at home.

Pupils' perceptions

Pupils were also asked about which topics were often discussed at home. Figure 5.2 shows the results for those topics which were identified as priorities by the pupils themselves.

Figure 5.2 Pupils' perceptions of topics discussed at home



The majority of P7 pupils thought that two of their priorities – smoking and safety – were often discussed at home. The same was true for S2 pupils with regard to

smoking and for S6 pupils with regard to alcohol. For all other topics, the majority of pupils reported that these were not often discussed at home.

To some extent pupils were in agreement with parents about those topics which were said by the majority to be often discussed at home. More than half of all pupils said that healthy eating was often discussed and more than half of the younger pupils at P7 and S2 agreed that safety and personal hygiene were often discussed at home.

Both in discussion and in response to the questionnaire, parents have stated that the school and the home should have joint responsibility for much of health education. There is clear evidence, however, that even in areas which have been identified as priorities, such as sex education and HIV/AIDS, many parents appear to be leaving the task to the school. In the next chapter, the contribution of the school to health education is explored.

6 The contribution of the school

I think health covers everything. It doesn't just cover physical things. It covers your emotions, mental state and your attitudes. There's a caring atmosphere and I think that's as important as anything.

Pupils, parents and teachers involved with health education were all asked about the school's contribution to health education. In addition, principal subject teachers in the secondary schools were asked about the extent to which health topics formed part of their department's responsibilities and the extent to which they were personally active in promoting health.

■ Primary pupils

Pupils from P4 and P7 were asked about health education topics which were discussed in school. More than three-quarters of the youngest pupils said that they had discussed looking after the environment (litter, pollution etc), keeping themselves clean, eating healthy food, being safe on the roads or in the home and keeping fit by doing exercise. The largest percentage (92%) said that they had talked with their teachers about getting on with friends. Exactly the same range of topics were often discussed by the majority of P7 pupils.

To some extent this list agrees with the list of priorities identified by teachers for primary pupils, ie healthy eating, personal hygiene, exercise and relationships. Certain other topics also identified by teachers as priorities were said by the pupils to be not so widely discussed. For example, over 80% of P7 pupils said that sex education , HIV / AIDS and drugs education were 'not very often' or 'never' discussed. In view of the research which indicates that young people start smoking at aged 10, 11 or younger, a surprising one-third of P7 pupils said that they never discussed smoking in class with their teacher.

■ Secondary pupils

In the secondary school, those topics which were said to be discussed often by the younger pupils, ie S2, are probably more a reflection of the subject-based curriculum rather than a separate health education programme. They included exercise, healthy eating, safety and personal hygiene all of which would have a high profile in either home economics, physical education or science. Relationships with friends was the only other topic reported to be discussed in school by more than half of S2 pupils. In the overall sample of secondary schools, the only priority health topic which was often discussed by the majority of S4 and S6 pupils with teachers was HIV / AIDS. Individual schools in the sample appeared to be better tuned to pupils' needs with, in one school, over three-quarters of both S4 and S6 pupils reporting that they often discussed HIV / AIDS, sex education and drugs education.

The contribution of subject departments

As part of the study we invited principal subject teachers to complete a questionnaire in order to carry out an audit of health education across the curriculum. The response rates from schools were not high and only 82 questionnaires were returned from the eight secondary schools.

Respondents were from 20 different subject areas and provided information on the extent to which health related topics formed part of their curriculum. Safety was a topic which was covered in a wide range of subject areas including all of those that had a practical or activity based element. Relationships with the family and relationships with friends were also covered by a range of subject areas.: drugs education and HIV/AIDS however are two of the topics selected as priorities by pupils of all ages which are not part of the core of any subject and therefore must be included in a separate programme. Even where a topic such as sex education is the core of some subject areas this does not necessarily mean that it can be safely omitted by the health education programme:

> *We tend to be more scientific than health. If something crops up as an emotional or moral issue I don't think there is a problem but it would depend on the teacher.*

The various subject departments clearly have the potential to relieve the social education programme of some health related topics but only if a systematic form of communication is established between the relevant departments. This does not always seem to be the case. In six of the eight schools there were some principal teachers who did not know if there was a member of staff with special responsibility for health education. Only one quarter of principal teachers said their department had been formally consulted about health issues by the senior management team and just over 40% said that their department had never been consulted. A few schools had carried out a cross-curricular audit of health issues but had reservations about its usefulness as information from an audit can quickly become out of date.

Primary/secondary links

In the eight pairs of associated schools both primary and secondary teachers were asked about the links they had with each other in relation to health education. Roughly half of teachers in both sectors (58% primary, 48% secondary) said that there were no links relevant to health. Where there were links these included

- regular meetings between headteachers
- 5-14 meetings
- PE and home economic specialists working in both sectors
- projects which began in primary and continued through to secondary
- visits from guidance staff to P7 pupils
- visits from P7 pupils to secondary schools.

Only a small minority of primary teachers and about half of secondary teachers who were interviewed knew which health issues were covered in early secondary or upper primary. Some of the primary teachers were, of course, from P4 and what happens in the secondary must seem very distant to them. Even some of the P7 teachers knew only by chance:

I happened to be at an INSET day where the health co-ordinator from the high school was there too.

Secondary teachers mentioned the difficulty in dealing with different associated schools and the variation between them. They also expressed the hope that health related links with the primary schools would improve with the implementation of *5-14 Guidelines on Environmental Studies*.

Teaching methods for health education

Much of recent research stresses that how health issues are introduced and developed is at least as important as what is included in the programme. Pupils were asked about the methods used to teach health education and whether these methods differed from other classes. Table 6.1 shows the percentage of pupils at each stage who reported being taught by a range of methods.

Table 6.1 Methods often used in health classes (%)

	P7	S2	S4	S6
Whole class together	85	93	95	80
Working/discussing in groups	82	68	65	70
Visitors taking the class	27	22	14	25
Acting out short plays	15	11	7	4
Watching TV/video	71	65	56	52

Results as to whether these methods differed from the rest of the classes showed a division between younger and older pupils. The majority of younger pupils (P7 and S2) said 'no' while a majority of the older pupils said 'yes'. When asked to comment on how these classes differed, the youngest pupils tended to focus on content with one quarter of pupils saying that they were more important:

Health is taken a lot more seriously than others because it is much more important. (P7)

You get told things you don't usually talk about. (P7)

Two main differences were highlighted by secondary pupils:

- more discussion and choice

We discuss different matters and we get to choose what things about health we want to know. (S2)

You can speak more freely in Social Ed than any other subject. (S4)

More discussion and input from pupils. (S6)

- classes are more informal and relaxed

You feel quite comfy with the rest of the class. The teacher makes it like that. (S2)

The teachers act casually and you can relax in the class. (S4)

It is a more personal attitude to education. This is important knowledge! (S6)

Pupils reported that much of the group discussion and viewing of video programmes was accompanied by worksheets which were used to highlight important issues for discussion. As pupils matured discussions were less likely to be structured in this way. Pupils also reported that they were more likely to

have the opportunity to express their own opinions and to have some say in the content of the lessons. Some of the older pupils related the different approach to the lack of examination pressure.

Teaching in sensitive areas

Teachers in both primary and secondary schools were asked if there were any strategies for coping with staff who were not comfortable discussing certain aspects of health education such as sex education. Most of the staff we talked to said that they personally had no problems but that if there were difficulties classes could be switched round for particular times or outside speakers could be invited in to talk to the class. In primary schools the headteacher was often available to talk to individuals or classes. In secondary schools relevant INSET for guidance staff was thought to be available for all who wanted to take advantage of it.

A few parents and health professionals did raise the issue that even when staff were perfectly willing to be open and to discuss anything the pupils wished to raise, the question of credibility with the pupils could be a barrier. Some health professionals believed that they were better equipped to discuss sex education than teachers although others felt that they would need some training in how to talk to children. Many school nurses, health visitors and medical officers of health indicated that they would welcome greater involvement and would be happy to assist teachers in planning a sex education programme. Some do this already. Their main problem is that with all the changes taking place in the health service, they do not know what the future holds for them or what their role will be in relation to schools.

Parents were also divided on whether it was better for teachers or health professionals to deal with sex education. Some thought that health professionals would be more matter of fact and have more credibility. Others felt that such sensitive areas should be covered by the people the children knew best and who knew the children best - the teachers:

I feel strongly that sex education, AIDS is done by educational people.

■ Parents' knowledge of the health education curriculum

Parents were asked which health education topics were already included in the school curriculum and to indicate if they would like more or less emphasis on any of these topics. Over half of all primary parents said that environmental health, exercise, healthy eating, personal hygiene, relationships and safety were included in the school health education curriculum. Drugs education is the only topic which primary parents identified as a priority but which is not, as far as most of them are aware, included in the health education programme.

For secondary parents there was considerable agreement across the age range that certain topics were of prime importance and Table 6.2 (overleaf) shows the percentage of parents who said that these topics were already included in the school curriculum.

More than half of all secondary parents were satisfied that each of the topics identified as most important was already included in their children's education.

Table 6.2 Priority areas which were already included in the curriculum

Pupils' needs	Secondary parents (%)
Drugs education	78
HIV/AIDS	55
Alcohol	64
Sex education	83
Smoking	75
Healthy eating	69

These proportions are considerably higher than the proportions indicated by their children where HIV / AIDS was the only priority said to be discussed by the majority of S4 and S6 pupils. Perhaps many parents simply take it for granted that these issues are being discussed in schools.

Few parents made any suggestions about topics on which they would welcome more emphasis in school. Those who did, mentioned drug education, smoking, alcohol, HIV / AIDS, sex education, healthy eating and first aid. The only additional topic suggested by primary parents was relationships. Apart from first aid, this list again reflects the priorities already identified.

Only one area - sex education - was identified by more than one parent as a topic on which there should be less emphasis.

■ Priority topics

Those topics identified as important by parents who responded to the questionnaire were also commented on by the parents who were interviewed. The difference was that these parents were able to elaborate on why and how they wanted certain topics to be taken up by schools:

Drugs education

There has been a forum of parents and school to do with drugs in the area although not at this school. The head would be willing if more than one school took part - he did not want people to think that his school had a drug problem.

primary parent

From P7 through to S6, drugs education was consistently at the top of the list of priorities and the one where the majority of parents wanted more emphasis. There were two distinctly different schools of thought on how drugs education should be handled. One stressed the softly, softly approach of self-awareness and learning to make health-enhancing decisions. A few parents wanted a much harder line taken on drugs and other harmful substances and advocated the use of shock tactics to scare the children:

For drugs I would like them to bring in an ex druggie who could tell them how it devastated their life.

Drugs, smoking and alcohol. I think it ought to be far more horrific. You need horrific pictures of lungs and people losing their legs - that hits home.

secondary parents

Particularly in areas where there are significant problems with injected drugs, parents stressed how they and the school needed to make the children aware of the dangers of touching needles from their earliest years. One parent drew attention to a potential problem in this for some children:

> *My daughter was diabetic. There was a talk in primary on syringes and of course she uses syringes. She got very confused. They were told not to touch them because they were dirty and she wanted to know if this applied to the ones she used. It wasn't the class teacher who gave the talk but it could have been handled more sensitively.*

secondary parent

Sex education

From P7 upwards, sex education was always in the top four areas of priority as identified by parents. It tended to draw more extremes of responses than other topics with about 20% of all parents wanting more emphasis but also a substantial minority wanting less emphasis or a different emphasis:

> *In school it's presented in a matter of fact way so they don't get alarmed and know it's just part of life.*
>
> *I feel that sex education is being pushed at them at too early an age. I think if it is going to be done in the school I'd be happier if it happened at secondary school than at primary.*

primary parents

> *Sex education needs to be earlier. I know some girls start their periods in P7 and know nothing about it. The parents are not likely to tell them and it's quite easy when they are that age. It gives them time to get through the puberty bit before they get to sex.*

secondary parent

Several parents from a number of different schools welcomed the opportunities to watch videos used for sex education. Many schools also gave parents the opportunity to withdraw children from sex education classes. Some parents felt that this did not go far enough:

> *If you are an atheist or a Jehovah Witness you can opt out of RE but if you are a Christian you can't opt out of what you see as unchristian teaching. Parents are allowed to withdraw children from Living and Growing programmes but it [sex education] comes at different stages. They feel it should be done separately and they can opt out.*

secondary parent

Healthy eating

Healthy eating was a topic considered to be more of a priority for the younger pupils up to about S2. However, a wide cross-section of parents in discussion raised the apparent contradiction of the school staff trying to educate pupils about a healthy balanced diet while junk food and drink were available on the school premises. The problems were not easily solved:

> *The school tried a health awareness programme and the tuck shop was asked to sell health bars - the health bars didn't sell at all.*

primary parent

Some parents would be happy to start with quite minor changes:

> *What I would like to see in our dinner school is chips taken off the menu at least twice a week so that they have the alternative of duchess potatoes or boiled potato.*

secondary parent

This is clearly an area where several school boards felt they ought to be able to make some sort of impact and they had been in contact with the school meal contractors with varying degrees of success:

> *We got in touch with the [school meals service] and spoke to staff at dinner school and got in touch with parents. They said they would make changes but I don't think they actually did.*
>
> *Healthy eating should be supported by the school meals. That is a point of contention as they aren't nearly as nutritious as they used to be The SB has little influence in this matter although we have written to the school contractor who does the meals and also to the Region.*
>
> *Parents were concerned about the number of E factors which might be included with the change in management of the school meals. We wrote to the Region and had a nice letter back saying that our points had been taken and a new contract would be made.*
>
> primary parents

Parents disagreed on the extent to which they thought school staff should be responsible for overseeing what the children could buy in the tuck shop or the dinner school:

> *I don't believe in restricting the source of supply. I prefer encouraging self responsibility . If they want some sweets they have it but they do it within the context of a balanced diet and dental care.*
>
> *I think it would be mainly up to the parents to go down and say to the school: 'look, I'd rather my child was not allowed to buy...'*
>
> primary parents

The report to the Chief Medical Officer on *The Scottish Diet* (SOHHD, 1993) must surely lend force to the concerns of teachers and parents who are trying to ensure that tuck shop operators and catering services provide healthier options and that consistent messages about healthy eating are being presented to children.

Exercise

Perhaps not surprisingly when parents were asked if they could suggest ways in which their children's school promotes healthy living, they very often talked about the PE programme. However, it was only noted as a priority for the youngest group of pupils. Again it was an area where opinions were strongly divided, with some parents believing that it ought to be compulsory for all pupils (and staff?) and others concerned about the effects on those who had little or no such inclinations:

> *Every one should do exercise. It seems too easy to opt out.*
>
> *Exercise is important but there is a cajoling side in PE that sometimes suggests that if you are not up to this there is something wrong. That can be hurtful.*

Other parents suggested ways in which the habit of exercise could be encouraged across the school community:

> *Daily exercise in school for pupils and staff even if it was only for 10 minutes.*
>
> *The likes of step -the kids love that kind of thing.*
>
> *A lot of kids in S6 would like to do a PE module.*

The impact of health education

The long term effects of health education are difficult to measure but we asked pupils at S4, S6 and recent school leavers to reflect back over their health education and to say whether they could think of any ways in which health education had increased their knowledge, influenced their thinking or influenced their behaviour.

Increased knowledge

In discussions with groups of pupils at S4 and S6 their reactions were mixed on whether or not their knowledge of health topics had increased as a result of health education in schools. Some felt they did know more about the high profile areas such as drugs education, smoking, HIV/AIDS and sex education but whether that was from school or other sources was difficult to say:

> *I think you need some kind of education from your teachers but ....you probably learn more from your mum or dad or asking or TV.* (S4)

When school leavers were asked in the questionnaire to say if heath education had increased their knowledge about health matters, at least half felt that their knowledge had been increased in the following areas: drugs education, HIV/AIDS, sex education, effects of alcohol and healthy eating. Considering that the first four of these are the areas identified as priorities these results are encouraging.

Influencing thinking

Again the responses from the group discussions were varied. Some individuals felt that their attitudes to drugs and solvent misuse had changed:

> *You get so much drummed into you over the years that you realise there are real dangers.* (S4)

Other pupils found it difficult to say whether there had been any effect or not:

> *Probably not consciously but maybe sub-consciously.* (S6)

Responses from school leavers showed that 61% thought that health education in school had had an impact on their thinking about HIV/AIDS. In all other areas only a minority of school leavers noted any impact.

Influencing behaviour

It is recognised that behaviour is more difficult to change and several pupils said that even with the knowledge they had about the dangers of substance misuse, for example, they would still want to experiment:

> *You have to try for yourself because you never believe unless you try for yourself.* (S4)

For some of the topics which were being discussed, asking about changes in behaviour may have been inappropriate at least for some pupils. However, one group of senior pupils who had recently been discussing relationships did think that they had changed their behaviour:

> *You give and take a bit more.* (S6)

Discussions on safety and HIV/AIDS were two other areas which were mentioned as having had an impact on behaviour.

The majority of recent school leavers did not believe that health education in schools had influenced their behaviour. The percentages of those school leavers who thought their behaviour had been influenced by health education is shown

for the priority areas which they themselves identified. The percentages for attitude and knowledge are also shown along with the figures for 'no impact'.

Table 6.3 The impact of health education on recent school leavers (%)

Priority area	Influenced behaviour	Influenced attitudes	Increased knowledge	No impact
Drugs education	17	39	64	14
HIV/AIDS	43	61	64	4
Alcohol	6	31	51	31
Sex education	34	46	60	10

According to school leavers' own reports, education on HIV/AIDS and sex education seems to have been most effective while alcohol education has been least effective.

Teachers' suggestions for improving health education

Teachers in both sectors were asked to suggest ways in which they thought health education could be improved in their schools. The need for more structure in the programme was highlighted by both primary and secondary teachers:

At the moment we don't really have a policy. There is no real progression and continuity.

primary teacher

More could be co-ordinated. People recognise it's important but it's not a requirement so people do bits of things. It would be beneficial to have a school policy.

secondary teacher

Both groups also referred to the need for expertise in the area:

Make each member of staff an 'expert' in some area of Environmental Studies so that they look out the material and become a resource in that area.

primary teacher

Create a health studies department and appoint staff who are trained in the approaches to health education which are suitable for young people.

secondary teacher

In-service training and more involvement with parents were also suggested. Food was a bone of contention with both sets of teachers making a plea for a concerted promotion of healthy eating. Rightly or wrongly, the catering services attracted a great deal of discontent as did vending machines and tuck shops:

The dining centre has gone commercial. The profits are made on the sweets.

The catering services in the Region don't back up your healthy eating programme.

primary teachers

You should go into the canteen and see what is eaten - nothing but chips and coke.

The vending machine spews out sweets and fizzy drinks. There's a bit of hypocrisy.

The school tuck shop makes a profit. It sells sweets and nothing but sweets.

secondary teachers

Teachers in the secondary sector were also very concerned about the place of health education in the curriculum:

Extra time and priority should be given to health education. Health is of vital importance and should not be squeezed.

Social education programme is being squeezed by things like Work experience, ROA and careers education.

Given that there will always be a limited amount of time to cater for formal health education, the next chapter looks at ways in which the school helps to promote health beyond the confines of the health education curriculum.

7 Health promotion

They have a very good relationship in this school between staff and pupils Teachers are very approachable. There is somewhere to go if you have problems and the children are aware of that. (secondary parent)

No matter how good the health education programme is, it is only one part of the schools' wider commitment to the promotion of good health. Each school is a working group of adults and children and contributes to the health of its members by the way in which it conducts its business and in its relationships among staff, pupils and the wider community. In this chapter the views of pupils, teachers and parents are provided on schools' health promoting practices.

■ Pupils' impressions

One section of the questionnaire for pupils of P7 upwards related to the ethos of the schools and to the importance of health education. Table 7.1 shows the responses from the various stages.

Table 7.1 Pupils' perceptions of health promoting practices in schools (%)

	P7	S2	S4	S6
In my school,				
health is important	87	58	47	41
the environment is safe and pleasant	65	36	46	56
there is a good selection of healthy foods	46	43	22	29
there is a no smoking policy for everyone	54	55	46	54
there are good links with parents	70	48	40	44
pupils are encouraged to make their own decisions	65	63	60	62
staff and pupils respect each other	62	36	26	36

P7 pupils were significantly more positive than secondary pupils. They were more likely to say that health was important in their school, that the environment was safe and pleasant, that there was a good selection of healthy foods, that there were good links with parents and that staff and pupils respected each other.

Pupils in rural schools were more likely than pupils in urban schools to say that their environment was safe and pleasant. They were also more positive about the availability of healthy foods.

Teachers' views

During discussions with teachers in the primary schools, they were asked to suggest examples of how the school promoted healthy living. The following were included:

- sports and clubs after schools
- no smoking policy
- healthy eating (including tuck shop and a well balanced lunch)
- fund raising for various good causes
- formal curricular aspects within Environmental Studies.

The hidden curriculum and the school ethos were almost always mentioned as being at least as important as other more specific measures:

> *We think of the school as one giant family. They're always encouraged to keep an eye on others whether they are younger or less able.*

Health co-ordinators in secondary schools

Health co-ordinators from all schools were asked, in interviews about the ways in which their school promoted healthy living. A wide range of activities were suggested, some of which were ongoing throughout the school curriculum and others which were special events:

- sports and activities (sometimes for staff and pupils)
- guidance/social education programme
- health policies
- health committees
- health days/weeks
- health information.

Many also mentioned the importance of a caring environment:

> *We try to make each person feel a part of the school.*
>
> *The main thing is that the school is a pretty happy school.*
>
> *Giving pupils a personal sense of value is more important than any other part of health education.*

Principal subject teachers

In the questionnaire to principal teachers, they were asked to indicate the extent to which they agreed with a number of statements about health promotion. The majority agreed that the following encouraged health promotion in their schools:

- regional policy on health
- school policy on health
- school development plan
- supportive senior management
- relevant staff development.

The largest numbers agreed strongly that a school health policy and supportive senior management were effective in promoting health. Over 50% were not sure

about or disagreed that the *5-14 Guidelines on Environmental Studies* and a school audit of health were helpful.

Principal teachers were also asked to what extent they personally were active in a number of aspects of health promotion. Almost three-quarters of teachers said that they were very active in:

- providing a healthy/safe environment
- promoting a sense of responsibility
- developing good staff/pupil relationships
- promoting the self esteem of pupils
- encouraging decision making skills in pupils

Fewer principal teachers (less than one quarter) said that they were very active in making clear the health promoting aims of the school or in developing good home/school links.

Teachers were also asked to describe ways in which they were active. The largest single group (33%) said that their courses encouraged the skills of decision making, taking responsibility and promoting the self esteem of pupils. Other principal teachers (25%) highlighted the importance of encouraging safety and hygiene in their classrooms:

Health and safety are essential introductory elements to all science classes.

I ensure that the cookery area is a safe working area and that the pupils understand and obey the rules for safety and hygiene.

Principal teachers also reported that they actively promoted good relationships and the self esteem of pupils by providing a supportive and encouraging environment in the classroom.

From the parents' perspectives

During interviews, 32 parents were asked to discuss wider aspects of health promotion - what the school did to promote good health. Parents referred to relationships among staff, pupils and parents and special programmes which involved the whole school community. The parents involved in these discussions were all, of course, members of the school board and are perhaps more likely than other parents to feel some sort of commitment to the school. There were very few negative comments. One secondary parent had the impression that 'personal well-being was high on the school's agenda' but worried that it might have a negative effect on educational standards. The remainder of comments were positive and supportive of the idea that the school had a role to play beyond that of the academic curriculum:

The head is very open to parents. She is an approachable person and that has given an ethos of approachability. People feel they are welcome.

primary parent

There is a family room in the school. They do different topics and have discussion groups. The reason I got involved they were having a parenting group about AIDS and sex education. My girls are now ten and I wondered how I would approach the subject so I went down. There's aerobics on Wednesday, speakers come to talk about different things, such as child abuse, alcohol, drugs etc. It's great. Quite a lot of the mums come down and they do a crèche too.

primary parent

They have an open night where they have a healthy eating table. Biology and Home Economics try to encourage healthy lifestyles and healthy eating. Adults are encouraged to come into the school for S grades or Highers.

secondary parent

They are taught from an early stage that the school is theirs and if they allow it to be abused they are the long-term sufferers. The attitude that you are not only responsible for yourself but for those around you is a very sound idea.

secondary parent

Findings from Phase 1

The work carried out in Phase 1 of the study and reported in the preceding chapters provides a fairly detailed picture of what was happening in health education with regard to the needs of young people and how these needs were being met. For the two pairs of associated schools which were to continue into the second phase of the project, individual findings related to the views of their pupils and parents were presented to each school and the next chapters describe how these schools reacted to the information.

8 Preparing for action

Phase 2 of the study involved working with two pairs of associated schools only. These school were selected according to the criteria referred to in chapter one as follows: Each school

- took part in Phase 1
- identified health education as a priority
- was interested in taking part in Phase 2.

One pair of schools was situated in an urban area, the other pair was in a rural area. A short description of each school is given. For convenience each pair of primary and secondary schools has been given the same name.

North City secondary school is an urban school with approximately 450 pupils. It has a very mixed catchment area and about half of the pupils come from areas designated as Areas for Priority Treatment.
North City primary school is an associated primary school about two miles from the secondary school. It has about 180 pupils and takes its pupils from a similar catchment area.
River Bank primary and secondary schools are in a rural area. Their pupils come from local towns and from outlying farms. The schools are next door to each other and they share the same senior management team. One of the assistant headteachers has responsibility for the primary department. The secondary school has about 450 pupils and the primary department has about 185 pupils.

For each of the schools, detailed findings from Phase 1 on the views of their own pupils and their pupils' parents were provided and over a period of one year, meetings were held with teachers and senior management in the schools on their reactions to these findings. At the end of the year, pupils were interviewed about their health education experiences and were invited to complete questionnaires. Questionnaires were also sent to all teachers in the primary schools and to principal subject teachers and teachers of social education in the secondary schools.

There was no intention that these schools should provide models of good practice in health education and promotion. Rather they were to provide a means of exploring the kinds of issues that are likely to arise in a school which is seeking to improve its health education and its health promoting practice on the basis of the identified needs of its own pupils and their parents.

Since only four schools were involved in Phase 2, this makes it impossible to generalise from the specific detail of their practices to schools country-wide. For example, one of the primary schools chose *Skills for the Primary School Child* (TACADE, 1991) as the vehicle for taking a new look at its school wide programme

of health education. The resource provided a framework for structuring their programme from P1 to P7. Another school might choose a quite different resource which would serve the same purpose. For this reason, we have avoided providing details on the practices of individual schools but have tried to highlight the main principles and procedures which will be relevant to all schools.

Preparation for Phase 2

It was recognised that a considerable amount of planning would be needed if schools were to make use of the findings from Phase 1 and that these findings would have to be communicated to schools as quickly as possible. Meetings were held with social education and senior staff in the secondary schools and senior staff in the primary schools during the first phase of the project to discuss the aims of Phase 2. The findings for each school were prepared over the summer months and communicated to schools during the first term of the 1994/95 session.

Presentations/ workshops for staff

During the last term of Phase 1 and the first term of Phase 2, presentations and workshops were prepared for staff. The first focused on current research including priorities for young people drawn from a number of different research studies, different approaches to health education and evaluations of these different approaches. The second, carried out after the results from Phase 1 had been collated, provided a detailed breakdown of the schools' own results including priorities identified for their own pupils and information on the views of parents on a range of topics.

Presentation and workshop 1

Information from recent research was collated to present staff with findings likely to be of importance in planning a health education programme. The information was presented under three headings:

- Priority areas for pupils of different age groups as identified by various research programmes
- Findings related to some of these priorities e.g. substance misuse and sexuality
- Evaluations of different types of health education programmes

  Information programmes

  Programmes which stressed values education

  Programmes which focused on interpersonal skills

  Resistance training programmes

  Peer education.

Part of the work of Phase 2 was to document the ways in which a school showed evidence that it was a health promoting community and the opportunity was taken at the first workshop to suggest and discuss a number of criteria which might be used to identify a health promoting school. Over the year of their involvement, staff in each school worked together to complete a health promotion booklet which itemised the ways in which the school was contributing to the promotion of good health. Staff were asked to say in what ways the school;

- made clear to staff, pupils and parents the aims of the school for the promotion of health

- provided a healthy environment with regard to safety, meals, buildings, playground and leisure activities
- encouraged healthy living and presented a realistic and attractive range of health choices
- promoted a sense of responsibility with respect to individuals, family and community health
- developed good relationships in the daily life of the school
- provided links with associated primary/secondary schools, home and community
- used specialists and available resources for advice and support

In Appendix 2 the information from the primary schools and from the secondary schools is collated separately to provide examples of ways in which these schools were promoting good health among the school community.

Workshop 2

Once the results from Phase 1 had been analysed for the total sample of schools, a personalised copy of each of the Phase 2 schools' own results was prepared. The results highlighted the following aspects

- Pupils' needs as identified by pupils, parents, teachers and health professionals
- Parents' views
  - Communication between home and school
  - The most appropriate place to discuss health matters
  - Awareness of health matters included in the school programme
  - Health matters discussed at home
- Pupils' views
  - Health matters which are very important
  - Health matters discussed in school
  - Health matters discussed at home
  - Health promotion in school
- Principal subject teachers' views (secondary schools only)
  - The extent to which they were active in promoting positive health.

The personalised results showed the findings for each individual school alongside the findings from the sample of eight pairs of associated schools which took part in Phase 1. These findings were first presented orally to teachers (including members of the senior management team) and later prepared as a booklet, several copies of which were sent to the individual schools.

Gathering information for Phase 2

All schools received a personalised copy of Phase 1 findings from their own schools and these findings were discussed during visits to the school. All schools also received copies of the health promotion booklet for completion by staff.

In North City primary school, regular meetings were held with the head teacher, senior teachers and teachers from P4 and P7. In River Bank primary school, most of the contact was through the assistant headteacher to discuss the

preparation and planning needed to bring about curriculum development related to health education. In both secondary schools discussions were held with staff with responsibility for the social education programme.

In all schools, discussions were held with the senior management team and other appropriate members of staff to explore a number of whole-school issues arising from Phase 1 findings.

At the end of the school year, semi-structured interviews were held with groups of young people from P4 and P7 in the primary schools and from S1 to S6 in the secondary schools. These pupils also completed questionnaires.

All teachers in the primary schools were invited to complete questionnaires as were principal subject teachers and social education teachers in the secondary schools. These questionnaires retained some of the relevant questions from Phase 1 but also contained questions relevant to the teachers' role in Phase 2.

The main focus in Phase 2 was in the schools' reactions to meeting the health education needs of pupils as identified by the young people themselves and their parents. Where individual schools selected some additional feature for improvement from the Phase 1 findings this is noted.

Phase 2

In the remainder of this report, chapter nine relates the changes to health education planned and/or implemented as a result of the project and reviews the extent to which the pupils' identified needs were met. This chapter includes relevant results from pupil interviews and staff and pupil questionnaires. Chapter ten discusses a number of whole school issues which arose from both Phase 1 and Phase 2 of the study and the final chapter reviews the implications for senior management, teachers and local authorities arising from the study and makes a number of recommendations to each group.

9 Reactions to the findings

Early in the first term of the session 1994/95, each school was presented with a booklet which outlined the views of its own pupils and their parents on the health education needs of young people. The schools were able to review their position in relation to whether or not they were meeting the perceived needs of their pupils and how satisfied parents were with the current situation.

Senior members of staff in the schools were asked how they could make use of the information contained in the personalised booklets which showed the results from their own pupils and parents alongside those of all the schools involved in Phase 1. In general, staff tended to focus on comparisons with other schools and to highlight those areas in which they were reassured about their own practices and those areas in which they seemed to be less effective than other schools. They also looked for situations where there was a good match or a mismatch between pupils' needs and pupils' perceptions of the present curriculum.

For each school this was the first time they had access to a systematic analysis of the needs of their own pupils in relation to health education and the following section discusses the extent to which teachers were able to take account of these needs in their health education curriculum.

■ Planning for change

Primary schools

Although both primary schools had identified health education as a priority, they were at different stages of development and there were differences in how they reacted during the second phase of the project. The research findings provided a staff development resource which teachers could use to reflect on their own practice. The extent to which practice changed depended on management and staffing strategies.

Staff development

In both schools, almost all staff attended a workshop at the beginning of the school year where findings from their own schools were presented and discussed. Teachers were able to examine the extent to which they were already meeting the needs of pupils and to look at areas of mismatch. Booklets setting out the main findings were left with the school for reference.

In North City primary school, *Skills for the Primary School Child* had been selected as a resource which would allow them to provide a framework for the development of health education across the school. One of the senior teachers attended staff development courses related to this course and led school-based in service for all staff.

In River Bank primary school, the assistant headteacher attended staff development courses and collected relevant resource material to plan for changes in the following year.

Management and staffing strategies.
As a result of drawing some of its pupils from Areas of Priority Treatment, North City primary school has the benefit of a senior teacher who in normal circumstances has a non teaching role. She was able to play a major role in the development of the health education programme. Senior staff encouraged the P4 and P7 class teachers to plan a health theme during the summer term of the 94/95 session.

In River Bank primary school, the assistant headteacher maintained the health education programme already in operation. He was concerned about the need to plan ahead especially for areas of health education which would be completely new to teachers. Imminent changes to staffing and other constraints which will be referred to later made it difficult to implement changes to the health education programme within the time scale of the project.

Senior staff from both schools took part in discussions on a number of whole school issues relating to health matters. In River Bank this discussion took place with senior staff from both the secondary and the primary sector.

Secondary schools
In the secondary schools, findings related to the individual schools were presented to staff as a staff development resource and again booklets containing the findings were made available mainly for the benefit of the social education staff. In both schools, there were aspects of health education such as healthy eating and exercise which were very much the prerogative of subject departments but in Phase 2 where the focus was on a few identified priority areas, these areas came almost entirely within the remit of the social education departments.

Management and staffing strategies
In both schools there were designated members of staff with responsibility for health education. Each school had a year by year programme for health education within a broader syllabus for social education. Again senior staff in both schools took part in discussions during Phase 2 on whole school issues arising from the project.

■ Meeting the needs of young people in primary schools

Findings from Phase 1 showed that from P7 onwards, there was considerable agreement among pupils, parents, teachers and health professionals on the health education priorities of young people. There was not the same degree of consensus at P4 where pupils and parents in both Phase 2 primary schools differed from teachers and health professionals by selecting drugs education most frequently as an area of priority. Primary schools and teachers of the youngest pupils in the study were, therefore, faced with the greatest challenge.

It became evident at an early stage that radical changes to the health education programme would not be possible within the time constraints of the project. Drugs education for pupils below the age of ten was a new concept for teachers of this age group and as such had considerable staff development implications.

To a large extent schools were not yet ready to accept the challenge of providing education on drugs, smoking and alcohol to children in P4. Perhaps the fact that neither teachers nor health professionals in Phase 1 had identified these areas as priorities for this age group made the need for change appear less urgent. For reasons which may have been to do with their rural situation, River Bank primary school saw such a move as even less appropriate than North City primary school although both sets of parents were in agreement about the priorities for health education of their children. Whether to introduce new areas of health education is not a decision which can be taken at the class teacher level and how senior staff make decisions between conflicting demands will be discussed later.

Evidence from teachers and pupils

At the end of the second phase of the study, a questionnaire was sent to all teachers listing the priorities as identified by the schools' own pupils and asking them to indicate if they agreed that these were priorities for the different age group. Teachers of P4 and P7 were also asked if they had included these priorities in their 1994/95 programme or if they had plans to include them in future programmes. In each school there was only one P4 and one P7 class. Since each school had a slightly different list of priorities, the findings are given separately.

North City Primary School

For P4 pupils, the identified priorities were

- drugs education
- smoking
- alcohol
- relationships
- safety.

Five teachers responded to the questionnaire and no teachers disagreed that these priorities were appropriate although two teachers were unsure about drugs education (choices for response were 'agree', 'disagree' or 'not sure'). The P4 teacher had included 'relationships' and 'safety' as part of her health education but not the other three priorities which she planned to include in future. She had touched briefly on smoking and alcohol as part of an introduction to a healthy living topic carried out in the summer term and was planning to expand on this in future. Although drugs education was not currently tackled formally during P4, the problems of drug misuse in the neighbourhood were such that all teachers from P1 onwards did join with parents in warning children of the dangers of touching discarded needles and syringes. The evidence from Phase 1 does not supply any detail about exactly what form of drugs education parents would like for children of this age and further discussions with parents would be needed to clarify if this was sufficient or if more was required.

For P7 pupils the priorities identified were

- drugs education
- sex education
- smoking
- safety
- healthy eating.

Four out of five teachers agreed that these were priorities for this age group and no teachers disagreed. Each area had been included for P7 pupils in the 1994/95 session. In this school, *Drugwise Too* (SOED/SRC, 1993) was used in P7 and the class had also been visited by the local police who were piloting a drugs education programme for primary schools. The introduction of sex education had previously been limited to informal chats by the P7 teacher usually if she was able to arrange to have the girls as a separate group. As a result of sex education being identified as a priority in Phase 1, this informal arrangement was replaced by a formal invitation to the local school nurse to provide a talk for P7 girls on puberty with a parallel separate talk for boys.

An additional aspect of Phase 1 had been identified by the P7 teacher as an area for improvement. She had noted that parents would have welcomed more involvement in health education and had set tasks on health education issues which pupils had to discuss at home with their parents.

When pupils were asked about what they had discussed in class, their responses mainly reflected the responses of teachers. However, there were some problems of interpretation. During interviews, P7 pupils remembered the visit of the school nurse and how she had discussed changes in their bodies. When asked in the questionnaire if they had discussed sex education in class only 2 out of 12 pupils responded positively. It may be that most pupils did not recognise a talk on puberty as having any connection with sex education or perhaps they did not count the nurse's visit as part of their normal classroom experience.

River Bank primary school

Areas identified as priorities for P4 pupils in the rural primary school were,

- drugs education
- smoking
- hygiene
- healthy eating
- alcohol.

Seven teachers responded to the questionnaire and only one teacher disagreed that drugs education, smoking and alcohol were priorities for this stage although three others were unsure. The priorities which were being met, hygiene and healthy eating, were part of the existing health education programme and were those which teachers and health professionals, as well as parents and pupils, had identified as priorities during Phase 1 of the project. There were no immediate plans to introduce the other areas.

For P7 pupils, the areas identified as priorities were

- drugs education
- sex education
- healthy eating
- smoking
- exercise
- safety.

Of the seven teachers who responded to the questionnaire, one teacher disagreed that healthy eating, exercise and safety were priorities for the top end of the

school, but only because she thought drugs education, sex education, smoking and alcohol were more important. Of the above list, only exercise and safety had been included for P7 pupils. Future plans for the P7 class were complicated by the appointment of a new P7 teacher to replace the previous teacher who retired at the end of the 1994/95 session. However, senior staff in River Bank were well aware that there was a need to expand the health education programme in the school to take account of issues such as drugs education, smoking and sex education. Previously these topics had been left to the secondary school and it was accepted that this was no longer feasible. Unlike North City PS the headteacher had decided against inviting the school nurse or health visitor into the classroom. The advantages and disadvantages of working with external agencies are explored in chapter ten.

The responses of pupils to what had been included reflected the responses of teachers. Pupils in P4 remembered talking about personal hygiene and healthy eating but not drugs education, smoking or alcohol. Pupils in P7 remembered talking about exercise and safety but not any of the other identified priorities.

Meeting the needs of young people in secondary schools

Evidence from teachers and pupils

When this project was first set up, clear differences in the needs of young people from different parts of the country were expected. This proved not to be so and there were only minor differences between the priorities of young people of all ages in urban and rural secondary schools. Although certain health education areas are catered for in different subject departments, the areas selected as priorities were almost exclusively within the remit of the social education departments and it is the responses from the questionnaires to social education teachers which are drawn on in this section.

North City secondary school

The same three topics were identified as priorities for S2, S4 and S6 pupils - drugs education, HIV/AIDS and sex education. Four social education staff completed the questionnaire and of these, two teachers taught S2 pupils, four teachers taught S4 pupils and one taught S6 pupils.

Where more than one teacher is responsible for the same year group, differences in the opportunities offered to pupils may occur. This appeared to be the case in S2 where both teachers who responded included drugs education but only one teacher included HIV/AIDS and sex education.

For S4 pupils each identified priority was covered by all four teachers who responded. This does not necessarily indicate any change due to their involvement in the project but reflects the fact that the school had already identified these as key areas for S4 pupils. However, two teachers did indicate that they had put more emphasis on drugs education and HIV/AIDS in the 1994/95 session.

In S6, there is a greater emphasis on careers education than on health education but the teachers who worked with S6 planned to include all three health priorities in future.

Responses from pupils were complicated by the fact that teachers of different groups covered different topics. All fourth year pupils interviewed recalled

discussion on all three priorities. All pupils in S2 had been involved in drugs education but only some had the opportunity to talk about HIV/AIDS and sex education.

North City secondary school is located in an area with recognised drug problems. Findings from Phase 1, showed that compared with other schools in the sample, North City was already catering for drugs education across all years and that this was recognised by pupils. HIV/AIDS was previously restricted to older pupils. Partly as a result of our findings and partly as a result of teachers' own perceptions of priorities, the intention is that HIV/AIDS will be included in the future S2 programme for all pupils.

River Bank secondary school

Priority areas identified for pupils at S2, S4 and S6 were largely the same. All three groups identified drugs education and HIV/AIDS. S2 pupils included smoking, S4 and S6 pupils included sex education. Three social education teachers completed the questionnaire, two of them taught each year.

All teachers agreed with the priorities identified for S2 pupils. Of the two teachers who taught S2 in 1994/95, one included all priority areas. The secondincluded drugs education but only referred briefly to HIV/AIDS in the context of relationships. There were plans to include more in future years. He/she did not include smoking as it was covered in S1.

Both teachers who taught S4 included HIV/AIDS and sex education. One did not include drugs education but again only because it was considered to havebeen covered adequately in the previous year.

At S6, the element of choice meant that different teachers covered different areas at the request of their pupils. One teacher disagreed with the identified priorities, but explained that this was only because his/her group considered that these topics were already included lower down the school and did not want to cover them again. However, where pupils wanted to discuss these topics, they could still be included 'in a different guise under the "Life away from Home" unit'. Priorities will change from group to group and where there is a choice teachers will want to cater for their own group preferences.

The main priorities for pupils at River Bank secondary school were already part of the social education programme and hence only minor adjustments and changes in emphasis were planned. Previously there had been a focus on alcohol education rather than drugs education as alcohol was thought to be more of a problem locally. The findings from Phase 1 confirmed staff in their opinion that this situation had changed and that the emphasis had to move towards more drugs education.

As with other areas of the curriculum, progression from P7 to S1 can be difficult. The secondary school was aware that its associated primary schools provided different experiences of sex education for their pupils. Since some schools were providing little or no such education, the sex education element of health education was increased at S1 until such time as all primary schools could meet the need themselves.

In Phase 1 of the study, a substantial minority of pupils had requested a course on first aid. During the 1994/95 session, senior staff identified an appropriate GSVQ course which would provide pupils with this opportunity. Setting up this course with a fully qualified teacher was not possible within the time-scale of the project but as an interim measure one of the social education teachers who was suitably qualified, provided his/her pupils with an introduction to first aid.

Again the responses of pupils depended to some extent on the social education classes to which they were assigned. All S2 pupils who were interviewed had been given the opportunity to be involved in education on drugs, sex education and smoking. All S4 pupils recalled discussions on all three priorities. S6 pupils did not recall specific discussions on the identified priorities but felt they could have talked about these matters if they had wished.

The pupils who took part in the first aid course were pleased to have the opportunity and thought that it should be available to all pupils.

■ Communicating with parents

Both secondary schools had noted that half of parents from all schools in the first phase of the project requested more information from schools on health education. Each school decided to update and extend the entry in the parents' handbook to meet this need.

■ Decisions not to meet certain identified needs

In some cases referred to above, the decision not to meet identified needs was a temporary measure. HIV/AIDS was currently introduced formally at S4 although pupils, parents and teachers agreed that it was also a priority for younger pupils. In both secondary schools, teachers were planning to start their HIV/AIDS programme at lower ages than at present. This was partly in response to the findings of the report and partly a response to their own perceptions of changing expectations.

Needs which pupils said were not being met, were sometimes part of the health education programme in other years. During the first phase of the study, pupils from S2, S4 and S6 were interviewed about their experiences in the current year and it was these results which were the basis of Phase 2. However, both secondary schools claimed that many of the health priorities were covered in other years (S1, S3 and S5). Social education classes cover a wide range of different aspects of education and, for example, career education, study skills and citizenship are likely to have a higher profile than health education at certain stages. In Phase 2, therefore, information was gathered from pupils of all years. The groups of pupils interviewed were drawn from a number of different social education classes and this meant that in some cases only certain members of the group had had the opportunity to discuss and be involved in certain areas of heath education. Tables 9.1a and 9.1b show the views of pupils from S1 to S4 on what was covered within the priorities for each school. 'Yes' indicates that all pupils in the groups interviewed said they had discussed these topics. 'No' indicates that no pupils recalled discussing these topics. 'Some' indicates that pupils from different social education classes had different experiences. For pupils at S5 and S6 the situation is complicated by choice within the social education programme.

Table 9.1a: Priority topics included from S1 to S4

North City	Drugs	HIV/AIDS	Sex education
S1	Yes	Some	Yes
S2	Yes	No	Some
S3	Yes	No	Yes
S4	Yes	Yes	Yes

Table 9.1b: Priority topics included from S1 to S4

River Bank	Drugs	HIV/AIDS	Sex education	Smoking*
S1	Yes	Some	Yes	Yes
S2	Yes	No	Yes	Some
S3	Yes	No	No	n/a
S4	Yes	Yes	Yes	n/a

* Only identified in Phase 1 as a priority for S2

The table shows that over each two year period (S1/S2 and S3/S4), all pupils will have had the opportunity to be involved in health education related to drugs education and sex education. HIV/AIDS is the one area where change is still required to meet the needs of younger pupils.

The different experiences of pupils in different social education groups may not be of concern where these experiences occur in optional areas. However, health education co-ordinators would need to be aware if any groups were missing out on the core social education syllabus.

In the primary schools, sex education at P7 was an identified priority for both pupils and their parents and was also endorsed as such by teachers. As a result of the findings from the project, North City primary school moved towards meeting this need, at least in the short term, by inviting the school nurse to talk to pupils. In River Bank primary school, senior staff intended that it should be introduced in the future but that more preparation and staff development time was needed first. The various constraints which make it difficult for schools to respond quickly to changing demands are explored later in this chapter.

At the end of the first phase of the project, young children (P4) and their parents identified a need for drugs education as the number one priority. It was not a priority identified by teachers or health professionals for this age group. However, the situation is continually changing and at the end of the 1994/95 session only one teacher from the primary schools thought that drugs education was not a priority for pupils at P4. Teachers in North City primary school where drugs education is already included at P7 are now planning to introduce the topic lower down the school. The recent availability of guidelines and resources for younger pupils (HELP and Drugwise First, SOED/SRC 1995) should assist them in meeting this challenge and satisfying the requirements of parents and pupils.

Local circumstances may make the situation more urgent in certain urban areas but unfortunately, it would appear that young people in rural primary schools may also be exposed to drugs misuse. River Bank primary school does

have plans to introduce drugs education and other priority issues at P7 but as yet has no such plans for lower down the school.

It could be useful for schools to consult with parents to find out if they have any particular concerns about drugs which they want teachers to discuss with the younger children. The recent publications referred to above will give teachers ideas from those involved in health education for younger pupils to spark of discussions with parents. If teachers still decide on the basis of professional judgement not to introduce a topic which has been prioritised by parents then there is a need for them to explain their reasons to the parents.

■ Constraints on meeting needs

Even where schools would have liked to meet the needs of pupils as identified by pupils and their parents, certain constraints limited the extent to which they could advance. Both external and internal factors created constraints. Some applied to both secondary and primary schools some applied to one sector only. Not all of these constraints were in evidence in this study but all could create potential difficulties.

External factors

Where a local or national priority has to be implemented, individual school priorities may have to be postponed. The advent of school development plans should make this a rare occurrence as SDPs are now accepted as the fundamental planning tool for the school which, once accepted, may not be overridden lightly. River Bank primary school had intended to make Environmental Studies 5-14 (and hence health education) the focus for its activities in the session 1994/95 but had to set this to one side to complete its commitments to the demands of English Language and Mathematics. It did not mean that health education was neglected as there already was a programme in place. It did mean that no changes resulting from the findings of the project were put into place during the original time-scale.

Time is always a constraint and each school had to work to a time scale for responding to the identified needs of parents and pupils which was set to suit the timing of the research project rather than the school.

The priorities for pupils from each school were collected from parents, pupils, teachers and heath professional by the research team. Having a third party act as a 'go between' may have made schools feel less 'accountable' to parents than if they had collected the information themselves.

Increasing demands on the personal and social development programme in secondary schools is a general problem, which means that career education, health education, study skills, records of achievement, work experience preparation all have to fight for a place in the programme.

Internal factors

Changes in staff due to retirement/relocation make it difficult for senior staff to plan ahead so that all teachers feel they have an input to the changes. Again this was more of a problem for River Bank primary which was facing major staff changes at the end of the 1994/95 session after a long period of stability. Not knowing the strengths and weaknesses of new staff created a hiatus in planning and implementing change.

Time is needed to plan, collect and become familiar with appropriate resources particularly in these areas which have not been covered previously such as drugs education or sex education. This created more problems in the primary sector. Staff also needed time to attend relevant professional development courses and to pass their experiences on to other staff.

Different staffing arrangements and management styles create different problems. Where the headteacher in a primary school can work with a non-teaching senior teacher and delegate some of the responsibilities for development to him/her, such development can move on apace. Where the headteacher also teaches and there are no non-teaching senior teachers, developments will inevitably be slower. There is also a balance to be struck between the two extremes of a centrally planned initiative which is passed to staff only after being prepared, tried and tested by senior staff and one which is developed by individual teachers working in isolation.

In the secondary schools, the needs identified by parents and pupils were close to those identified by teachers and the major areas of priority were already covered in existing health education programmes. There was an identified health education co-ordinator whose particular responsibility was to cater for health education within a social education programme. Primary schools seemed to be more constrained than the secondary schools in their ability to meet the identified needs of their pupils. There was less agreement among parents, pupils and teachers about the priorities for younger pupils and hence primary schools had to make many more changes to take account of pupils' and parents' priorities. Environmental Studies 5-14 was still at an early stage of implementation in schools and did not as yet provide a framework for progression and continuity. The recently published HELP package (SOED/SRC, 1995) should provide additional support and guidance to staff in the area of health education

■ Wider issues

During regular visits to schools it became obvious that there were many issues arising from health education which could not be settled at the classroom level but which needed to be tackled by senior staff on a whole school basis. These issues and schools' ideas on how to deal with them are discussed in the next chapter.

10 Health education matters

Health education is concerned with the promotion of physical, social and mental well-being of the individual. It includes not only imparting knowledge about what is beneficial and what is harmful, but also involves the development of skills which will help individuals to use their knowledge effectively. Pupils need the opportunity to develop attitudes and values which will enable them to make choices which will be of value now in their present lives and also in the future. (SHEG/SCCC, 1990)

What is health education?

Before discussing some of the major issues which arose during the period of this project it is worth drawing attention to the differing perceptions of what health education means to different groups. Many parents and pupils, during the early stages of open discussions, took a fairly narrow view of health education. There was a tendency to focus on exercise, to talk about healthy eating and to be concerned about dangerous substances - drugs, alcohol and tobacco. To a large extent this was also true of school nurses, health visitors and school doctors. The stress was on the physical aspects of health, on topics rather than skills. Teachers and professionals involved in health promotion, tended to have a wider view of health education and were often the only adults to talk about the importance of relationships and the building of self esteem as relevant health concerns. Current thinking on health education emphasises a three-fold model where physical, emotional and social well-being are equally important as the quotation at the head of this chapter makes clear (SHEG/SCCC, 1990). Teachers will have to consider how to communicate this wider view of health education to parents and pupils alike. A shared understanding of what is meant by health education is essential if the home and the school are to take joint responsibility for its implementation.

Issues for discussion

During visits to schools it became clear that there were a number of issues which were applicable to all schools whether primary or secondary, urban or rural. These issues included how schools made decisions about the content of the health education curriculum, how they handled sensitive or confidential matters and their relationship with potential partners in health education such as parents and specialist agencies. Meetings were held in each school to discuss with senior management teams ways of managing these issues.

How schools make decisions about the health curriculum

In Phase 1, information was gathered about the needs of young people of different ages from P4 to S6. Although there was considerable consensus among the different groups about what these needs were, differences were also noted.

In particular, parents and pupils tended to focus more on the risk factors related to health education than teachers and health professionals. Parents and pupils (and to some extent medical specialists) tended to think in terms of physical health and to focus on dangers to health. Teachers and health promotion professionals included social and emotional health and (while not ignoring potential dangers) looked for ways to help pupils promote a sense of positive well being.

All schools felt that they as professional educators with access to guidance from regional and national sources had the main responsibility for deciding what to include in the health education curriculum. However, they also recognised that parents had an important role to play and that it was their responsibility to liaise with parents, to invite them to discuss the health education curriculum and to clarify, where necessary, reasons for their choice of appropriate topics at different ages.

Local authority and national support

Teachers have access to a great deal of support on health matters and these include both local authority guidelines and guidance from bodies such as the Health Education Board Scotland (HEBS) and Health Promotion Units. There is also a wide range of resources including texts, videos and packages on all aspects of health education. Some authorities and health-related reports provide potted summaries of health education resources which can help teachers to make their own selection among the many available.

In River Bank secondary school, the local authority adviser in guidance who worked in conjunction with the local health promotion unit was cited as an important consultant. She could provide support and advice to the school in making any difficult decisions and would also be able to tell them what was happening in other schools. This could be of considerable importance to rural schools where they may feel isolated and uncertain of what is happening elsewhere.

When schools are planning a meeting with parents about their health education programme, it may be worth asking the local authority adviser to attend to provide a more global view of current developments and thinking in this area.

INSET courses are provided around the country both for basic guidance training and in relation to specific resources or specific aspects of health education such as heath promotion. Colleges of Education are beginning to offer postgraduate certificates to further improve the professionalism of teachers of social education. Good professional development is considered by trainers and teacners alike as essential in preparing teachers to work with young people particularly in relation to the more sensitive areas of health.

Audits on health education across the curriculum

In educational terms, an audit is a systematic examination of some aspect of education which involves the collection of evidence on a school-wide basis.

In recent years, cross curricular audits have become increasingly popular in monitoring the introduction and development of, for example, study skills, technology and health education. Each year, North City secondary school carries

out an audit of health education across the curriculum to help staff to plan a health education programme within the social education department. The proforma for this exercise had been refined over the years and is sent out to all departments which are likely to have an input on some aspect of health education. The headings for the audit include:

- Physical fitness
- Growth and development
- The body
- Well being (health promoting factors, lifestyle)
- Damaging factors (Drugs, alcohol, smoking, AIDS)
- Nutrition
- Hygiene
- Health and safety
- First aid
- Health/environment.

Subject areas are marked against years S1 to S5/6 and where an aspect of health is treated in a subject choice (from years S3 to S6), this is noted. Each year the assistant head teacher with responsibility for social education confers with colleagues in the social education department to identify particular gaps in the health education programme:

> *When youngsters go into S3 by virtue of subject choice, they cover aspects of health education specifically related to certain subjects. What we do in Social Education is to ... identify what has not been covered and give that to the entire year group*

The school finds the audit has been a useful tool in helping them to plan their health education programme over a number of years.

Limitations of audit

Other schools have also tried audits and have identified several limitations. Many audits are limited to a list of topics and little is learned about the strategy used to develop a topic or about the skills that are involved. Even where subject departments do include a topic relevant to health education it is rarely covered in sufficient depth except where it forms a major part of that subject ie healthy eating in home economics or exercise in PE. Some subjects such as sex education are covered in science but the approach taken is likely to be different and much narrower than in social education. Other subjects such as English and drama can cover a wide range of health issues but they are not the core of these subjects and will change from class to class and teacher to teacher. There is a limit to how often it is worth repeating this kind of audit to keep up with changes in provision.

Most importantly, there are very few audits of pupils' experiences and these experiences can be mixed even within one department. In almost all cases, the audit itemises the intentions of the teacher. An individual pupil or group of pupils asked to provide an audit of the same programme of activities may have quite different perceptions of what is going on in the classroom which could provide valuable feedback to teachers.

Pupil and teacher perceptions of the content of health education

When teachers are planning their health education programme, they are likely to include decision making exercises, role play situations and activities designed to build self esteem as significant factors within drugs education. When pupils talked about drugs education during interviews, they talked about knowing what dangerous drugs look like, what they do your body and how you become addicted. The health education programme may therefore signal drugs education to the teacher but not to the pupil. Another area ripe for misunderstanding between pupils and teachers is that of sex education. If a primary school concentrates on changes due to puberty, children may not recognise this as an aspect of sex education. Pupils in the secondary schools may spend time talking about relationships without in any way relating this to education about sex. There is a danger that an over-concentration on skills leads to the neglect of knowledge of some areas. Pupils need both factual knowledge and skills.

As with all other aspects of education, telling pupils the aim of the activities and making clear the links with other aspects of the curriculum helps pupils to set their experiences in context.

■ Coping with sensitive matters

Health education contains topics which many adults find difficult to discuss with each other. Discussions between the generations is even more of a problem. The great majority of teachers we spoke to, both in the primary and the secondary, felt that they personally had no problems in discussing sensitive matters such as sex education with pupils. Guidance teachers in the secondary sector were satisfied that opportunities for relevant INSET were available if needed and most had taken advantage of such cours It was felt that teachers who had been through an appropriate course of professional development would be quite at ease in coping with sensitive areas. However, even when teachers are genuinely willing to discuss any matters the pupils want to raise and have attended all the relevant INSET courses, the issue of credibility can be a barrier - particularly at the secondary level. Willingness has to come from both teachers and pupils. Teachers who find pupils are not prepared to open up with them as they do with other members of staff may have to accept that their strengths lie in other areas and withdraw from certain topics.

In our discussions with members of the senior management team the problem was tackled as a hypothetical question: 'If one of your teachers was uncomfortable in discussing certain topics how would the school cope with the situation?'

Both primary and secondary schools felt there would be few problems in coping with the situation where a teacher expressed reservations about discussing, for example, sex education. Solutions included the temporary rearrangement of classes or team teaching in the secondary sector and having a senior member of staff in the primary sector work with the teacher in classroom or take the class him/herself if that was necessary. Schools felt that such rearrangements were used in other areas of the curriculum to build on the individual strengths of teachers and that this was no different. Another solution which was suggested was to invite someone from outside the school, such as the school nurse or specialist agency to talk to pupils. The schools considered that sensitive issues were best discussed where good relationships had been developed between

teachers and pupils and that the use of outsiders not the ideal answer. Several teachers and health professionals were of the opinion that the expertise of the health professionals was put to better use when used to develop the skills of the class teachers. The role of outside speakers/agencies is discussed later in this chapter.

Schools were more at a loss as to how to cope with the possibility of a teacher having little credibility with pupils and not recognising that this was the case. It was suggested that the PT Guidance in secondary schools or a senior member of staff in the primary school was likely to be aware of the situation and would arrange to help in the class. Provided this was not an unusual occurrence in the school there would be no problem. Good relevant staff development was considered essential in helping teachers to identify their needs and prepare for coping with sensitive issues.

At what age should sex education start?

Both primary schools in Phase 2 recognised that they were not meeting the needs of older pupils with respect to sex education. Both were also uncertain of the best age at which to start. Teachers commented that by P7, discussions with classes on the physical aspects of sex education (including puberty) were made impossible because of the problem of boys teasing girls about deeply personal issues. Introducing information about the physical side of sex at an early age within a topic on 'knowing about your body' would appear to be one way of overcoming this difficulty.

Discussions about relationships with friends which was an important part of health education in the primary school was considered to be an ideal preparation for discussion about sexual relationships which would take place in the secondary schools but it was realised that more specific information on the changes which take place at puberty could not be left until S1.

The age at which girls start to menstruate has been gradually falling and some girls will start their periods in P6. If primary school teachers are not happy in discussing such matters with their classes, the solution is not to ignore the issue and hope it will be dealt with at home. For many children, these matters are not discussed at home. What seems to be clear is that no girl should reach the age of puberty without knowing what is going to happen to her body and that it is insufficient to leave the decision about when to introduce this topic to the judgement of the individual teacher. It must be written into the health education programme so that no groups of children are omitted. Most local authority and national guidelines have clear advice on this matter.

Single sex classes

For some issues, there may be occasions when separate discussions for girls and boys would be welcomed. There were two stages at which this was suggested; P7 and S4. Several teachers of P7 pupils mentioned that they tried to organise time to talk to the girls on their own about the changes that take place at puberty. There was a feeling that boys of this age were insufficiently mature to benefit from such talks and that the girls appreciated the freedom to talk comfortably with others of their own sex.

At S4 it was a group of girls who first raised this issue and again the difference in maturation between boys and girls motivated their thinking. They felt that the boys were not mature enough for a serious discussion of, for example, the pros and cons of abortion or the different types of contraception available.

Many staff in both primary and secondary schools had identified single sex classes as desirable on occasion but often found it difficult to arrange because of practical constraints of staffing and time. Staff were also anxious to ensure that both sexes were equally aware of the issues surrounding sexuality and recognised their relative responsibilities to each other.

Parents' concerns

In the area of sex education, it is difficult for schools to meet the perceived needs of parents with respect to sex education for their children. Schools will not be able to please all of the parents all of the time. Even where the majority of parents want sex education included in the health education programme, some parents want it discussed earlier, some later. Some think they ought to be able to remove their children from classes, others think parents ought not to have this option. The case is argued for having it as a special separate class and for having it treated as a normal subject 'rather than as something different and taboo'. All schools can reasonably be expected to do is to consult their own parents within the framework of regional and school policy and then keep them informed as fully as possible as to the content and format of the programme. Most schools do this already, having a standard letter which is sent to parents whenever the topic of sex education is about to be introduced. Parents are also invited into schools to watch any videos which are to be used and to discuss with the teacher the approach to be taken. Some parents find these sessions very helpful in giving them ideas on how to broach the topic with their own children.

The role of outside agencies

There are now large numbers of organisations who will offer their services to schools particularly in relation to drugs, HIV/AIDS, sex and sexuality and alcohol - the most sensitive and controversial areas. Some of these organisations have been involved with schools for many years such as the police and health professionals, others have sprung up in reaction to recent high profile issues such as AIDS and sexuality. Some agencies are proactive, inviting schools to make use of their services, others are reactive and come at the invitation of the school. Clearly schools need to plan carefully how to make the best use of external agencies and develop criteria for selecting among them.

North City secondary school was situated in an area where drug misuse was a very real problem and all kinds of agencies and individuals were involved in a variety of health related projects in the community. To a large extent, the school depended on the local authority for clearing external agencies. If the agencies had been vetted by the region, then the school was at least prepared to consider how they could contribute to the school programme. Individual teachers also had many personal contacts outside school because of their involvement in the community.

Over the years, ideas about how to approach drug education have changed. At one time shock/horror treatment was considered effective until research

showed otherwise. Schools have moved away from this approach and are wary of asking, for example, ex drug addicts to talk to pupils:

> *If you get an ex drug addict who is now OK, kids think they can dabble in drugs and be OK. You have to be very careful about the message which is coming across.*

Several potential problems with external agencies and their representatives were raised by the schools involved in the project. In both primary and secondary schools, the positive relationships which teachers had worked hard to develop with their pupils were considered to encourage open discussion in a familiar and supportive atmosphere. There was a concern that some health workers and representatives of external agencies lacked the educational knowledge and skills needed to work with classes of young people. Even where an individual from an agency established a good rapport with a class and was prepared to be open and to follow the pupils' leads, the next visit from the same agency could be a different individual with none of the necessary skills.

There are clearly quite different models of partnership between education and health professionals which can work successfully with a carefully managed strategy. A recent report on two Greater Glasgow Health Board school health education programmes (Lowden and Powney, 1994) involved a successful collaboration in the classroom between a health project worker and a social education teacher:

> The presence of external workers on the modified programme was valued by teachers and pupils because of their increased knowledge and related credibility and also because they were more able than teachers to be, or be perceived as being, non judgmental.

River Bank secondary school had a different problem in that there were few external agencies on their doorstep. The local health promotion unit's policy was to work with the educational development service to provide staff development and support for teachers but not to work directly to pupils. The local police had been involved in a drug awareness exercises with parents, teachers and pupils which had been organised by the PTA. These were both official agencies who were drawing on knowledge from their own area of expertise. To a large extent staff were wary of inviting external agencies into the school without having a very clear idea of what their message would be and how they would interact with pupils. It was considered essential that the visit had to be planned in collaboration with the class teachers and that the teachers remained responsible for their own pupils and used the expertise of the visitor as an additional expert resource.

In River Bank primary school, staff had decided against asking the school nurse into school to take the lead in sex education although the school nurse was a regular visitor to the school and often took part in projects. However, staff believed that professional training was needed to help children learn and that the school nurse or health visitor who was not trained to teach could not take on a teaching role. The school nurse confirmed that she felt her most effective role was to support the staff in any health related projects but not take on a teaching role.

In order to move quickly on introducing an element of sex education to meet the needs of pupils, the headteacher in North City primary school invited the school nurse into school to play a limited role in discussing issues of puberty with P7 pupils. He was disappointed, however, that the school nurse had not been in

post long enough to get to know the children as he would have preferred someone who already had a trusting relationship with the children. The P7 teacher considered it desirable that she should remain in the class with any visiting specialist so that she could respond to questions which might arise from the visit. If the intention is to take sex education beyond the limited aspect of puberty then current theories suggest that children should learn about sex education within the context of relationships and feelings and this can only be done over a period of time. Not all school nurses would have the necessary training for this task.

In some cases outside agencies take a far more radical view of their own special areas than schools or parents are prepared for. Some agencies are now talking about safe drug taking in recognition of what they see as an inevitable move towards the gradual social acceptance of certain drugs. Schools may not take this approach as long as drug taking is a criminal offence.

The general consensus among the schools in this project was that teachers were the best people to teach pupils about all aspects of health education. Teachers were trained to teach and were in a position to develop good relationships with pupils. Where teachers were uncertain about teaching drugs education and sex education, because of what they perceived as a lack of knowledge or a lack of the necessary skills it was a short term solution to invite outside specialists in to school. They welcomed the support of external agencies and specialists to help teachers develop appropriate skills, extend their knowledge and keep them up to date with the latest research and development. An effective partnership between schools and outside agencies depends on making the best use of each other's particular strengths.

Policy documents from local authorities are useful in providing guidance to schools on how to make the most effective links with outside agencies. The following is an extract from Tayside's document 'Putting People First' (1993) and stresses the notion of partnerships:

> A productive partnership between visiting contributors, educators and learners will
>
> • help the visitor to understand the context of the contribution (what preceded and what will follow)
>
> • discuss the reasons for the visit from the point of view of the learners' identified needs and the ways in which s/he can best contribute towards meeting these needs
>
> • discuss the agenda which the visitor may wish to bring to the meeting; identify where that agenda will increase the value of the visit; pre-empt any situation where s/he may want to put forward one point of view as the right one
>
> • assure the visitor of appropriate support from the educator during the visit and provide that support as required
>
> • involve the learners as much as possible in organising and participating in the visit
>
> • include some brief evaluative activity to find out whether the learners' expectations were and the visitor's intentions were met

- ensure that the visitor is aware his/her contribution is appreciated.

It is important that the educator is present throughout the visit - to learn, to take ultimate responsibility for the well being of both the group and the visitor and to be in a position to facilitate appropriate follow up to the visit.

There is an important role for local authorities in advising schools on the specialist field of knowledge of each agency which will take pupils' understanding forward.

Implications from the research

Implications arising from the issues discussed above and from the lessons learned during the project are described in the final chapter. Where appropriate, recommendations based on evidence from the project are also suggested.

11 Implications and recommendations

Each of the schools involved in Phase 2 was at a different stage of development and faced different problems in trying to improve their delivery of health education within the time-scale of the project. The secondary schools both had social education programmes which already included the main priorities as identified by pupils and their parents. Their reactions to the findings from Phase 1 involved an increased emphasis on drugs education and sex education and a lowering of the age at which HIV/AIDS was introduced. Some individual teachers put the changes into place during the 1994/95 session, others planned to do so in the next session.

The primary schools were faced with the need for more radical changes particularly in relation to the younger group of pupils. Staffing structures in North City primary school, which included a non teaching senior teacher, enabled the school to move ahead more quickly in both planning and implementing change. River Bank primary school was constrained by imminent staff changes to maintain its existing health education programme while planning ahead for change in the future.

Discussions with pupils, teachers and senior staff raised many issues which are likely to be relevant to schools other than those involved in the project. In this final chapter, the implications of these issues are addressed to senior staff, teachers and staff in local authorities. Where appropriate, recommendations based on evidence from the project are suggested.

Implications for senior staff

Not surprisingly one lesson to be learned from the project is the time needed by schools to plan and implement changes in practice. This time lag is exacerbated when the changes arise from the findings of an external agency such as a research team. The schools' own planning is driven by an identified need and is a gradual process of considering what has to be done to meet this need, what exists at present, what resources need to be gathered, what new skills the staff need, how to get these skills, who needs to be consulted, how responsibilities will be shared and how the changes can be incorporated into a cohesive programme across the department or school. When faced with a time-scale which is not their own and which has to take its place among the many other competing priorities, change in the first year is bound to be patchy.

It would have been to the benefit of all four schools in Phase 2 and to the research if it had been possible to have a one year gap in the project for schools to carry out their planning followed by implementation in the next school year. However, these are the realities and challenges of school life which continually face schools and researchers who work in schools. Opportunities have to be taken as they arise and lessons learned from the difficulties.

Working with parents

Parents and teachers have different perspectives on health education and need to work in partnership to ensure that all three aspects of health - social, emotional and physical - are valued.

Primary schools accepted the need to introduce sex education to their pupils. They had problems in deciding how much sex education was needed for young people and at what age to introduce this sensitive topic. From our discussions, it is likely that while parents identified sex education as a priority, they will be divided on the questions of how much and when? Senior staff will have to seek guidance from other sources to help them make decisions and the obvious sources are regional and national guidelines. Many local authorities have recently updated their policies on health education and have clear guidance on sensitive issues. Schools should not feel the they are operating in a vacuum.

There are probably no schools anywhere in Scotland who can now take the view that their pupils do not need education about drugs. If senior staff in primary schools have no plans as yet to introduce drugs education into schools or are concerned about how they should do this, now is an opportune moment as resources and guidance become available.

Teachers accepted that health education was the joint responsibility of the home and the school. The needs identified by parents for their children in this study sometimes matched those identified by teachers but sometimes differed. Teachers cannot always assume that the choices made by the teaching profession are more informed than those of parents. Schools need to explore the views of their own pupils and parents and be prepared to act on the findings.

Where schools feel that they have sound professional reasons for not taking account of the wishes of parents, they need to communicate these reasons to parents.

Working with external agencies

Teachers sometimes feel that they need the help of specialists in other fields to provide the best health education for their pupils. External support agencies can be effective partners with schools in health education provided that there is sufficient forward planning and co-operation between the school and the agency.

Where schools invite or welcome visitors from outside agencies into the classroom, senior staff should ensure that, on each occasion, information is gathered in a systematic manner about the strengths and limitations of the visit.

Recommendations

- Funders of research, researchers and staff in schools involved in research must be realistic about the time needed to plan and implement curricular changes.
- The school's handbook to parents should stress the breadth of the health education curriculum and include more information for each year.
- Schools should take advantage of the guidance available from local authority resources to help them in discussions with parents on issues which might be controversial or sensitive.

- Staff in primary schools should involve parents in a discussion on recent guidance on drugs education.
- Schools should canvass the views of pupils and parents on issues which are recognised to be the joint responsibility of the school and the home.
- Where there is a difference between teachers' views and parents' views staff must explain their position to parents.
- Schools should develop a set of criteria which can be used to set the standards for effective planned partnerships with local support agencies.
- Visits to classes from external agencies should be evaluated to determine the extent to which they meet pupils' expectations and the visitors' intentions.

Implications for teachers

Pupils in secondary schools appreciated the different atmosphere in many health education classes, the range of different activities and the opportunity to talk freely on topics of their choice. While recognising that all pupils must have a core of health education, time should be built into the programme to allow a degree of choice. It seems ironic for any social education course which seeks to develops decision making skills to have such a full programme that pupils cannot make decisions about what to discuss. Often choice was only an option for the oldest pupils.

When pupils were provided with the opportunity to learn something of areas which interested them their particular expectations were not always met. For example, in relation to HIV/AIDS and drugs education they learned about how to protect themselves from HIV/AIDS and about different kinds of drugs. They had not found out how HIV/AIDS or the different drugs affected the body.

When pupils were recalling what they had discussed or experienced in health education, their interpretation sometimes differed from that of teachers. The link between relationships and sex education was not always clear to pupils nor was the link between decision-making skill exercises and drugs education.

Recommendations

- A core and option model of health education should be considered for all years which would allow an element of choice for pupils
- Teachers should try to ascertain what their pupils already know and what they would like to know.
- Teachers should evaluate their own health education classes in terms of content, teaching approach and pupil expectation.
- Teachers must tell pupils why they are taking part in certain activities and how these activities relate to other aspects of the curriculum.

Implications for local authorities and national bodies

Some local authorities are further ahead than others in assisting schools with health education and may already have fulfilled some of the recommendations suggested. The quantity of health education guidance, packages and resources which are available to schools is enormous. Staff with responsibility for health

education are aware of far more material than they can ever hope to evaluate. A review of existing resources and packages which provides information both on the content and the teaching strategy used could save valuable time and allow better informed choices.

Policies and guidelines on health education are being published from many different sources. Health education covers a wide range of topics including controversial and sensitive issues and the full reports are often of considerable length. Teachers need help to find their way about these reports quickly.

Local authorities are probably best placed to provide schools with information about outside agencies which would enable effective partnerships to be developed. Schools should know what the special expertise of each agency is, whether their role is that of consultant, staff trainer, provider of materials or teacher, what kind of approach they are likely to use or promote in the classroom, whether they have any particular bias and if they charge schools for their services.

Recommendations

- Local or national bodies such as health promotion units, HEBS or the SCCC should provide regularly updated advice and training on appropriate use, selection and evaluation of existing resources.
- Lengthy policy and guidance documents should include separate executive summaries referenced to pages in the full report.
- Local authorities should compile a register of local agencies involved in health education which teachers could turn to for independent information.

The role of the school

The goals of health education are long term. If young people can be helped to lead healthier lifestyles this will in turn affect future generations. The Scottish Office recognises the important role schools have to play in furthering these goals.

> Health education in schools is an important element and it is Government policy to encourage health education issues to be tackled within the context of a comprehensive programme of social education and personal development. (The Scottish Office, 1992).

There is always a need to look for ways in which schools can improve their effectiveness. From this and other recent reports on health education, we now know quite a lot about the health education needs of young people as identified by themselves, their parents, teachers and health professionals. These needs are being met using a range of teaching approaches including dissemination of knowledge, group discussions, role play, drama and links with external support agencies. However, we know little about whether these teaching approaches match the preferred learning styles of young people and this is an area which research might usefully explore in the future.

Health education covers some of the most sensitive and controversial matters likely to be raised in school. Much depends on the relationship between pupils and teachers. Pupils need to feel a sense of worth, a sense that they matter as individuals in all their contacts within the school. A school which sets a high priority on relationships and consideration for others at all levels is likely to be more effective than one in which health education is a matter for guidance and social education staff only.

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Appendices

Appendix 1: *Questionnaires (primary and secondary)*

A selection of the questionnaires used in Phase 1 and Phase 2 of the study are included. Parallel questionnaires for pupils were used in Phase 2. Questionnaires for primary and secondary teachers used in Phase 2 were specific to the Phase 2 schools itemising their own pupils' priorities.

A Questionnaire for P4 pupils (Phase 1)
B Questionnaire for pupils from P7, S2, S4 and S6 (Phase 1)
C Questionnaire for parents (Phase 1)
D Questionnaire for primary teachers (Phase 2)

Appendix 2: *Tables of health promoting activities (primary and secondary)*

This is a collation of the self reported activities which Phase 2 schools listed using given criteria. Activities from both primary schools have been combined and similarly for both secondary schools.

A Health promoting activities (Primary)
B Health promoting activities (Secondary)

Appendix 3: *Social education syllabus (secondary)*

Certain aspects of education in the secondary school are the responsibility of various subject departments. The priority areas identified by and for pupils in this project were catered for in social education (SE). The syllabus listed here for River Bank secondary school does not include the other aspects of social education such as careers education, study skills, time management, work experience preparation etc.

A similar syllabus was not used in the primary schools where health education was delivered through a variety of means including

Environmental Studies
Appropriate themes
Special projects

HEALTH EDUCATION AND PROMOTION IN SCHOOLS

Questionnaire for pupils in P4

Health education helps young people to be healthy and happy both in school and out of school. By answering these questions you can help us to find out what young people of your age think is important about health.

If you find it difficult to answer any of the questions, ask your teacher for some help.

Put a tick in the box to show if you are a boy or a girl.

boy ☐ girl ☐

1 There are some people who help us to look after ourselves. Have any of the following people **visited your school to talk to your class?** Draw a circle round either 'Yes' or 'No' to show if they have talked to you in school.

Example: *if a dentist has visited the school to talk to the class put a circle round 'Yes' as shown below.*

Dentist	*Yes*	*No*
Lollipopman/ lady	Yes	No
Fire fighter	Yes	No
Policeman/woman	Yes	No
Dentist	Yes	No
Doctor	Yes	No
School nurse	Yes	No

2 Have you talked about any of the following topics **with your teachers** since you have been in P4? Draw a circle round either 'Yes' or 'No' for each topic to show if you have talked about it in P4.

Illness and disease	Yes	No
The way your body works	Yes	No
Keeping yourself clean	Yes	No
Eating healthy food	Yes	No
Looking after the environment (e.g. litter, pollution)	Yes	No
Keeping fit by doing exercise	Yes	No
Smoking	Yes	No
Getting on with friends	Yes	No
Getting on with your family	Yes	No
Safety on the roads or in the home	Yes	No
First aid	Yes	No
Taking drugs or sniffing glue	Yes	No
The effects of alcohol	Yes	No

3 We want to know how **important** you think it is to **know about** these health topics. Draw a circle round 'Very' if you think the topic is **very important** to know about, or 'Quite' if you think it is **quite important.**

Illness and disease	Very	Quite
The way your body works	Very	Quite
Keeping yourself clean	Very	Quite
Eating healthy food	Very	Quite
Looking after the environment (e.g. litter, pollution)	Very	Quite
Keeping fit by doing exercise	Very	Quite
Smoking	Very	Quite
Getting on with friends	Very	Quite
Getting on with your family	Very	Quite
Safety on the roads or in the home	Very	Quite
First aid	Very	Quite
Taking drugs or sniffing glue	Very	Quite
The effects of alcohol	Very	Quite

4 Write down what you feel are the **three <u>most important</u>** things for young people of your age to know about health.

1.

2.

3.

5 Have you talked about any of the following topics with someone in your **family**? Draw a circle round either 'Yes' or 'No' for each topic to show if you have talked about it with your family.

Illness and disease	Yes	No
The way your body works	Yes	No
Keeping yourself clean	Yes	No
Eating healthy food	Yes	No
Looking after the environment (e.g. litter, pollution)	Yes	No
Keeping fit by doing exercise	Yes	No
Smoking	Yes	No
Getting on with friends	Yes	No
Getting on with your family	Yes	No
Safety on the roads or in the home	Yes	No
First aid	Yes	No
Taking drugs or sniffing glue	Yes	No
The effects of alcohol	Yes	No

Thank you for your help.

HEALTH EDUCATION AND HEALTH PROMOTION IN SCHOOLS

Questionnaire for pupils

Health education is intended to help young people be healthy and happy both in school and out of school. For this reason it is important that pupils themselves should have a say in what is included in health education in schools.

Replies to this questionnaire will be seen only by the researchers. Your name does not appear on the questionnaire.

Please put a tick in the appropriate boxes

1. Are you male? ☐1 female? ☐2

2. What year are you in?

   P7 ☐1 S2 ☐2 S4 ☐3 S6 ☐4

3. Have you had any lessons or discussions **this year** with your teachers about the following health matters? Draw a circle round **one** number in each row to say how often you have these discussions.

   For example, if you do not very often have discussions about drugs then put a ring round 3 in the first row as shown below.

	Very often	*Often*	*Not very often*	*Never*
Drug misuse	*1*	*2*	*3*	*4*

	Very often	Often	Not very often	Never
Drug misuse	1	2	3	4
Effects of alcohol	1	2	3	4
Environmental health (e.g. litter, pollution)	1	2	3	4
Exercise	1	2	3	4
First Aid	1	2	3	4
Healthy eating	1	2	3	4
HIV/AIDS	1	2	3	4
Personal Hygiene	1	2	3	4
Relationships with family	1	2	3	4
Relationships with other young people (including bullying)	1	2	3	4
Safety	1	2	3	4
Sex education	1	2	3	4
Smoking	1	2	3	4

4. How important is it for young people of your age to know about the following health matters? Draw a circle round **one** number in each row to say how important you think each one is.

	Very important	Quite important	Not very important	Not at all important
Drug misuse	1	2	3	4
Effects of alcohol	1	2	3	4
Environmental health (e.g. litter, pollution)	1	2	3	4
Exercise	1	2	3	4
First Aid	1	2	3	4
Healthy eating	1	2	3	4
HIV/AIDS	1	2	3	4
Personal Hygiene	1	2	3	4
Relationships with family	1	2	3	4
Relationships with other young people (including bullying)	1	2	3	4
Safety	1	2	3	4
Sex education	1	2	3	4
Smoking	1	2	3	4

5. Are there any health matters which are **not** listed above which you think are very important for people of your age to know about?

6. What do you think are the **three** most important things for young people of your age to know about health?

1. _____

2. _____

3. _____

7. The following question is about methods of teaching which might be used in your class. Draw a circle round **one** number in each row to say how often each method is used in **health education**.

	Very often	Often	Not very often	Never
Teacher teaches whole class together	1	2	3	4
Pupils work or discuss in groups	1	2	3	4
Two or more teachers work with one class	1	2	3	4
Pupils complete worksheets	1	2	3	4
Visitors to the school take the class	1	2	3	4
Pupils act out short plays about health matters	1	2	3	4
Pupils watch videos/TV programmes	1	2	3	4

8. Is the way that health education is taught different from the way other subjects are taught?

Yes ☐1 No ☐2

If it is different, in what way is it different?

9. Have you discussed any of the following health matters with members of your family? Draw a circle round **one** number in each row to say how often each area is discussed with your family.

	Very often	Often	Not very often	Never
Drug misuse	1	2	3	4
Effects of alcohol	1	2	3	4
Environmental health (e.g. litter, pollution)	1	2	3	4
Exercise	1	2	3	4
First Aid	1	2	3	4
Healthy eating	1	2	3	4
HIV/AIDS	1	2	3	4
Personal Hygiene	1	2	3	4
Relationships with family	1	2	3	4
Relationships with other young people (including bullying)	1	2	3	4
Safety	1	2	3	4
Sex education	1	2	3	4
Smoking	1	2	3	4

10. If you had problems in any of the following health matters who would be **the first person** (or group of people) that you would go to for advice? Draw a circle round **one** number in each row (or complete the 'other' column) to show who you would go to for advice.

	Family	Friends	Teacher	Other (please say who)
Drug misuse	1	2	3	_____
Effects of alcohol	1	2	3	_____
Environmental health (e.g. litter, pollution)	1	2	3	_____
Exercise	1	2	3	_____
First Aid	1	2	3	_____
Healthy eating	1	2	3	_____
HIV/AIDS	1	2	3	_____
Personal hygiene	1	2	3	_____
Relationships with family	1	2	3	_____
Relationships with other young people (including bullying)	1	2	3	_____
Safety	1	2	3	_____
Sex education	1	2	3	_____
Smoking	1	2	3	_____

11. In what ways does your school try to ensure that staff and pupils are happy and healthy in school? Draw a circle round **one** number in each row.

In my school ...	Yes	No	Not sure
it is clear that health is important	1	2	3
the environment is safe and pleasant	1	2	3
there is a good selection of healthy foods	1	2	3
there is a no smoking policy for everyone	1	2	3
there are good links with parents	1	2	3
pupils are encouraged to make their own decisions	1	2	3
staff and pupils respect each other	1	2	3

Thank you for completing this questionnaire

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HEALTH EDUCATION AND HEALTH PROMOTION IN SCHOOLS

The Scottish Office Education Department has asked the Scottish Council for Research in Education (SCRE) to carry out a programme of research into health education and health promotion in Scottish schools.

For this project we are working in a number of secondary schools and their associated primary schools in Scotland. The range of relevant groups who are being asked to respond to interviews and questionnaires includes health education co-ordinators, teachers responsible for teaching health education in schools, area health board personnel, health professionals connected with the school, pupils at P4, P7, S2, S4 and S6 and parents of these pupils.

Your child's primary school has agreed to co-operate with us in our project. We have already visited the school to talk to several members of staff. We are now inviting parents of selected classes of pupils to complete a questionnaire for us.

Health education is intended to influence young people both in schools and in the wider context of life beyond school. For this reason it is important that parents should have a say in what is included in health education in schools. We would, therefore, be grateful if you could find time to complete our questionnaire.

Replies to this questionnaire will be treated in the strictest confidence. The names of respondents and their schools will not be published in the report of the project.

Please return the questionnaire to SCRE in the reply paid envelope by **Friday 20th May, 1994**.

Questionnaire for Parents

1. Please tick a box for each child you have in either **P4 or P7** to show whether he/she is male or female and which year he/she is in at school.

	P4	P7
Male	☐ 01	☐ 01
Female	☐ 01	☐ 01

2. In what ways are you actively involved with the primary school?

Please circle one number in each row

	Yes	No
Member of the PTA	1	2
Member of School Board	1	2

Other (please describe) _____

3. Do you think the school or the home is the **most** appropriate place in which to teach young people about the following?

Please circle one number in each row as appropriate

	School	Home	Both
Drug misuse	1	2	3
Effects of alcohol	1	2	3
Environmental health (e.g. litter, pollution)	1	2	3
Exercise	1	2	3
First Aid	1	2	3
Healthy eating	1	2	3
HIV/AIDS	1	2	3
Personal Hygiene	1	2	3
Relationships with family	1	2	3
Relationships with other young people (including bullying)	1	2	3
Safety	1	2	3
Sex education	1	2	3
Smoking	1	2	3

Please answer the following questions in relation to your primary school child(ren).

4 How often do you discuss the following topics at home with your child?

Please circle one number in each row as appropriate

	Very often	Often	Not very often	Never
Drug misuse	1	2	3	4
Effects of alcohol	1	2	3	4
Environmental health (e.g. litter, pollution)	1	2	3	4
Exercise	1	2	3	4
First Aid	1	2	3	4
Healthy eating	1	2	3	4
HIV/AIDS	1	2	3	4
Personal Hygiene	1	2	3	4
Relationships with family	1	2	3	4
Relationships with other young people (including bullying)	1	2	3	4
Safety	1	2	3	4
Sex education	1	2	3	4
Smoking	1	2	3	4

5. Which of these areas have been included in health education in primary school for your child?

Please circle one number in each row as appropriate

	Yes	No	Not sure
Drug misuse	1	2	3
Effects of alcohol	1	2	3
Environmental health (e.g. litter, pollution)	1	2	3
Exercise	1	2	3
First Aid	1	2	3
Healthy eating	1	2	3
HIV/AIDS	1	2	3
Personal Hygiene	1	2	3
Relationships with family	1	2	3
Relationships with other young people (including bullying)	1	2	3
Safety	1	2	3
Sex education	1	2	3
Smoking	1	2	3

6. Are you satisfied with the health education provided in your child's primary school? *Please tick one box only.*

Yes ☐1 No ☐2 I don't know much about the health education programme ☐3

If you would like **more** emphasis placed on any of the areas listed in question 5 please say in which areas.

If you would like **less** emphasis placed on any of the areas listed in question 5 please say in which areas.

7. What do you feel are the **three** most important health areas for young people of your child(ren)'s age to know about?

P4 pupils 1. _____ 2. _____ 3. _____

P7 pupils 1. _____ 2. _____ 3. _____

8. How does the school communicate with parents about current health education matters?

Please tick boxes as appropriate

School Handbook	☐ 01
Newsletter	☐ 01
Letters to parents	☐ 01
Parents' evenings	☐ 01

Other (please describe briefly) _____

9. What opportunities are parents given, by the school, to be involved in their children's health education?

Please circle one number in each row as appropriate

Parents are given the opportunity to ...	Yes	No	Not sure
provide input into the school's policy on health education	1	2	3
attend parent workshops on health education (to try out materials or have sample lessons)	1	2	3
attend parents' evenings where health education is discussed	1	2	3
participate in health lessons with pupils	1	2	3
approve health education materials (books, videos, worksheets)	1	2	3

Other opportunities (please explain briefly) _____

_____

10. Are you happy with the opportunities given to you for involvement in your child's health education?

Please tick one box only

Happy with the present level of involvement	☐ 1
Would like to be more involved	☐ 2
Would like to be less involved	☐ 3
Not sure	☐ 4

If you would like to be more involved, please suggest how.

Thank you for completing this questionnaire

A questionnaire for Primary School teachers

1. Which Primary class do you teach? _____

2. Have you been involved in any staff development training in health education?

   Yes ☐ No ☐

   If yes, was this

Regional INSET	1
PAT	2
Other	3

3. As part of this project, a booklet was prepared for the school giving information from your own pupils, their parents and teachers about the health related needs of young people and other matters. Some of this information may be of more use to teachers than others. To what extent would **you** find the following useful?

	Very Useful	Useful	Interesting but not useful	Not relevant
Pupils' own views of their needs	1	2	3	4
Parents' views of pupils' needs	1	2	3	4
Parents' views on communication between home and school	1	2	3	4
Pupils' views on the contribution of your school to health education	1	2	3	4
Pupils' views on how your school promotes good health	1	2	3	4
Teachers' views on their own role in promoting good health	1	2	3	4

4. Were you involved in a health education project/lessons with your class in the session 1994/95? Yes ☐ No ☐

If you did health education with your class in the 1994/95 session did you include any of the following topics and did you give any of these topics more or less emphasis than previously?

Primary 1 - Primary 4 teachers

List of topics	Yes	No	More emphasis	No difference	Less emphasis
Drugs education	1	2	1	2	3
Smoking	1	2	1	2	3
Hygiene	1	2	1	2	3
Healthy eating	1	2	1	2	3
Alcohol	1	2	1	2	3
Safety	1	2	1	2	3
Exercise	1	2	1	2	3

Primary 5 - Primary 7 teachers

List of topics	Yes	No	More emphasis	No difference	Less emphasis
Drugs education	1	2	1	2	3
Sex education	1	2	1	2	3
Healthy eating	1	2	1	2	3
Smoking	1	2	1	2	3
Exercise	1	2	1	2	3
Safety	1	2	1	2	3
Alcohol	1	2	1	2	3
Hygiene	1	2	1	2	3
Relationships with peers	1	2	1	2	3

Health promotion

5. Staff in your school have also been involved in completing a booklet providing examples of how good health is promoted throughout the school.

Have you seen or heard of this booklet? Yes ☐ No ☐

Did you contribute to the booklet Yes ☐ No ☐

6. To what extent would you agree that the following encourages health promotion in your school?

Please circle one number in each row

	Strongly agree	Agree	Disagree	Strongly disagree	Not sure
Regional policy on health	1	2	3	4	5
Supportive local authority staff	1	2	3	4	5
School policy on health	1	2	3	4	5
School Development Plan	1	2	3	4	5
School audit of health promotion	1	2	3	4	5
Supportive senior management	1	2	3	4	5
Relevant staff development	1	2	3	4	5
Guidelines on 5-14 Env. Studies	1	2	3	4	5

7. To what extent are you personally active in the following aspects of health promotion?

	Very active	Not very active	Fairly inactive	Not at all active
Making clear the health promoting aims of the school	1	2	3	4
Providing a healthy, safe environment (as far as it is within your control)	1	2	3	4
Encouraging healthy living by example	1	2	3	4
Promoting a sense of responsibility to others	1	2	3	4
Developing good staff/pupil relationships	1	2	3	4
Developing good home/school links	1	2	3	4
Actively promoting the self esteem of pupils	1	2	3	4
Encouraging decision making skills	1	2	3	4

If you are very active in any of these areas please give an example.

8. Last year, pupils in your school identified the following as their priority needs. Do you agree that each is a priority for this age group?

P4 pupils	Agree	Disagree	Not Sure
Drugs education	1	2	3
Smoking	1	2	3
Hygiene	1	2	3
Healthy eating	1	2	3
Alcohol	1	2	3

If there are other areas which you think are important for this age group please write these here.

P7 pupils	Agree	Disagree	Not Sure
Drugs education	1	2	3
Sex education	1	2	3
Healthy eating	1	2	3
Smoking	1	2	3
Exercise	1	2	3
Safety	1	2	3

If there are other areas which you think are important for this age group please write these here.

Please answer the following question if you taught P4 or P7 in the 1994/95 session or are teaching P4 or P7 this year. If this does not apply go to Q10.

9. Did you include or do you plan to include the following topics in your health education project/lessons?

P4 teachers	Have included this	Have plans to include this	Do not intend to include this
Drugs education	1	2	3
Smoking	1	2	3
Hygiene	1	2	3
Healthy eating	1	2	3
Alcohol	1	2	3

P7 teachers	Have included this	Have plans to include this	Do not intend to include this
Drugs education	1	2	3
Sex education	1	2	3
Healthy eating	1	2	3
Smoking	1	2	3
Exercise	1	2	3
Safety	1	2	3

10. What do you think are the priority needs for the age group that you teach?

1.

2.

3.

Thank you for completing this questionnaire

The Health Promoting Primary Schools

Health promoting aspects of the primary school	*North City Primary School*	*River Bank Primary School*
• Make clear to staff, pupils and parents the aims of the school for the promotion of health.	School handbook for parents and staff. INSET on personal and social development.	Joint handbook for primary/secondary. Parents and pupils are aware that healthy eating and healthy living are covered by topic work.
• Provide a healthy environment with regard to safety, meals, buildings, playground and leisure activities.	School policy on health and safety. Regular fire drills. Active and on going PE Scheme implemented with the help of specialist teachers from the secor dary sector. Playground supervision during interv.ls and lunch-times.	Road safety : A major project organised each year on cycling proficiency which culminates in passing a cycling proficiency test organised by the local police. Teachers also take the responsibility of watching for poor road safety out of school hours. School has an ongoing campaign to encourage children to wear safety helmets when cycling. Where children have easy access to rivers and lochs swimming is very much encouraged and is available to children from P1 upwards. Parents are very much involved with this to help with the youngest children. Adventure playgrounds have been built in two areas of the playground - one for P1 to P2 and one for older children. A supervisory rota system is used to minimise accidents. The school insists on set meals for P1, P2 and P3 pupils and then monitors the change over to : nack meals to ensure that the meal is balanced.
• Encourage healthy living and present a realistic and attractive range of health choices.	Health topics are taught throughout the school Infants - *Me, myself.* Infants/Juniors - *Teeth* - incorporating input an visits from dental health specialists. Junior/Senior - Topics involving "bullying". Senior - *Jimmy on the Road to Superhealth; Drugwise Too.*	Notice board is used to advertise clubs and activities.

Health promoting aspects of the primary school	*North City Primary School*	*River Bank Primary School*
• Promote a sense of responsibility with respect to individuals, family and community health.	Project work : Infants - The Family Seniors - Health based topics e.g. safety, hygiene and moral issues. Novels are used to look at a range of personal and social development topics. Visits to health centres. Displayed work on health topics in health centres.	Bullying Policy : There is a whole school policy which covers bullying and the Region has provided leaflets to parents and pupils on how to handle bullying. Staff feel it is important to always get both sides of the story. School pupils produced a drama on bullying which was broadcast by a local radio station. Developing campaigns related to litter and recycling to encourage responsibility for the care of the environment.
• Develop good relationships in the daily life of the school.	Creation of good ethos in the school. Use of *Promoting Positive Behaviour* and *Promoting Positive Relationships*. Senior pupils help to look after infants during wet intervals and lunch-times.	Promote a positive ethos. Staff watch for unusual behaviour patterns. Teachers have re-organised and paid more attention to monitoring areas in the school where children feel unsafe.
• Provide links with associated primary/ secondary schools, home and community.	Secondary PE teachers take lessons in the school. Guidance staff from the secondary visit the primary school to ease the transition from P7 to S1. Guidance staff meet with primary staff to discuss requirements for special needs children. Several courses are run for P7 pupils at the secondary. These include art, technology and use of the library. P5 pupils liaise with local nurseries and the National Childrens' Home family centre. Visits from the minister. Parents afternoon. Headteacher and the depute headteacher hold meetings with parents.	Guidance staff from the secondary visit the primary school to ease the transition from P7 to S1. Secondary home economics staff work with the older pupils in the primary and the pupils visit the secondary for individual cooking. Parents are involved in helping with swimming lessons for the youngest pupils. PTA - organised a drugs awareness talk for the parents.

Health promoting aspects of the primary school

- Be familiar with and use specialist and available resources for advice and support.

North City Primary School

Regular contact with psychological services staff.
Visits from dental hygiene.

River Bank Primary School

PE specialist visits the school once a week. The specialist also provides a follow up programme.
Local school nurse, doctor, dentist and police visit the school.
Specialists such as the social worker, the occupational therapist, the educational psychologist, the speech therapist and the physiotherapist visit when appropriate.
School liaises with the GP in the local surgery for any medical problems with children.
Teacher designated as the child protection officer attends all relevant courses.

The Health Promoting Secondary Schools

Health promoting aspects of the secondary school	*North City Secondary School*	*River Bank Secondary School*
• Make clear to staff, pupils and parents the aims of the school for the promotion of health.	School handbook Staff handbook Departmental syllabus e.g. home economics, physical education, religious education, science. Social education programme Teacher notes for social education programme INSET for social education Guidance Family Learning Unit Dining hall choices No smoking policy Discipline policy School rules Library information Parents' handbook Newsletters/leaflets PTA and school board meetings (information on drugs education etc. discussed) Parents' meetings	School/regional policies on health education. School handbook distributed to all S1 parents.
• Provide a healthy environment with regard to safety, meals, buildings, playground and leisure activities.	Health and safety policies Practical departments-emphasis on health and safety within the particular discipline - e.g. technical, computing, business studies, home economics, physical education, science etc. Regional policies on healthy eating for catering services. Dining hall open during the intervals. Litter picks Extra-curricular activities-lunch time clubs; before school sports. Library facilities	Health and safety co-ordinator in the school. Risk assessments are made in all leisure and class activities. Alarm and fire door systems Regular fire drills Fire appliances checked regularly. Staff and prefect supervision of recreation areas and playgrounds.

Health promoting aspects of the secondary school	*North City Secondary School*	*River Bank Secondary School*
• Encourage healthy living and present a realistic and attractive range of health choices.	Through the curriculum particularly - home economics, religious education, and social education. Within social education- Use of *Skills for Adolescence; Drugwise; It's my Life; Real Deal; Escape -AIDS;* anti-bullying materials; careers programmes; social and vocational studies The S1/S2 science course and the standard grade science and biology courses contain topics relating to healthy lifestyles. Access to library resources Liaison with community groups and promotion of evening groups and activities as recreation choices.	Promoted through the social education syllabus. Subject departments promote healthy living ideals through their class teaching. The school provides a leisure activities programme for all pupils as part of the curriculum. Some staff and pupils take regular exercise together on a voluntary basis e.g. jogging, hillwalking, skiing.
• Promote a sense of responsibility with respect to individuals, family and community health.	Certain departments are particularly responsible for this e.g. social education, home economics, physical education, biology and science. Caring atmosphere in the school. Family Learning Unit Good liaison with families in cases of problems from all staff.	Promoted through a structured social education syllabus. Certain departments are particularly responsible for this e.g. home economics, physical education and biology. Physical education provide SCOTVEC modules in health and fitness.
• Develop good relationships in the daily life of the school.	Social education programme S1-S6 to promote good relationships - *Skills for Adolescence;* anti-bullying materials. Family Learning Unit runs small support groups for vulnerable S1 youngsters and individual and family counselling sessions. Guidance/registration teachers regularly meet with pupils to discuss options, careers etc. Information is disseminated to staff from guidance staff and vice versa. Social and vocational studies-recipe book sold to staff, pupils and parents; lunch for staff; Easter party for nursery children. School clubs/discos/teams run by staff. School assemblies Christmas fete	Ethos forms a part of the school policy. Anti-bullying policy Daily staff/pupil relations-there tends to be a fairly relaxed atmosphere between most staff and pupils.

Health promoting aspects of the secondary school	*North City Secondary School*	*River Bank Secondary School*
• Provide links with associated primary /secondary schools, home and community.	Strong links with associated primaries - regular visits by headteachers to and from the schools. Visits from learning support, guidance and subject teachers to primaries. Occasional case conferences on primary transfers. General parents' nights and information evenings. Two day induction day and one day visit for P7 pupils. Parents invited to induction meeting for S1 pupils. Visits from minister. Family Learning Unit provides links with the home and community. Home visits are frequently made and local community meetings are attended. Social and vocational studies-involves visits to local sports clubs and other places of interest. Pupils are encouraged to find out about what is available in the community and to make contact by letter or telephone. Pupils are involved in placements within the community e.g. in local nurseries and primaries.	Primary/secondary liaison day-guidance staff visit all feeder primaries. Induction days for P7 pupils. Parents' evening for parents of P7 pupils going into S1. P7 pupils have the opportunity to go on skiing trips with the secondary pupils. Industrial awareness day involving pupils from the school and another secondary school. Reporting to parents is done regularly. School newspaper termly informs parents of school events. Community officer groups make various contacts with the community. These include : contact with the Rotary Club for mock interviews; visits to local industries; senior and junior youth clubs and various school shows and choral events.
• Be familiar with and use specialists and available resources for advice and support.	Guidance team and support group liaise with : social work; educational psychologist; health services; special needs departments; police; local community groups; community education and various drugs related agencies. There is a Joint Assessment Team which works with pupils. It consists of various specialists : the educational psychologist; senior social wrkers; senior IT officer; school medical officer; attendance officer and various drug related agencies. Family Learning Unit has a remit for working with outside agencies for pupils in trouble or at risk. It has strong links with social work. Links with educational psychologist for assessment and counselling. Mainstream support teacher available for pupils with Record of Needs.	Specialists from outwith the school are used in PE health modules. Rugby and hockey coaches are used in PE. Dance workshops are held with visiting tutors. Outside speakers are used in various departments. In particular in S5/S6 social education classes have talks about careers and health topics. In S6 *Life after school* conferences are held which use a range of visiting experts to talk to S6 pupils and other leavers.

Appendix 3: Social Education Syllabus for River Bank Secondary School

Year 1	*Resources*
General health (6 periods) What is health? General aspects of good health and care of the body. Coverage includes diet, exercise, personal hygiene, mental and physical fitness.	Health Education Kit - *Health is what you make it.* Also Health Pamphlets. Social Education Kit - *Good Health* particular section on Common Ailments.
Smoking (5 periods)	Health Education Kit - *Calculating the Odds, Its Your Life* - Chapter 9. Social Education Kit - *Drugs, Drink and Tobacco.* Raising the Issues. *So you want to talk about smoking?* - pack and video.
Living and Growing (9 periods) Sex education - new materials being used programmes 1-6 + selected supporting worksheets.	*Living and Growing* - Grampian TV series. Pamphlets on Growing Up etc. Social Education Kit - *Sex and Sexes.* Lifelines Book 2 - Family Matters. Health Education Kit - *Coming of Age; Lifestyles.* SPUC - *How you Began* - models.
Health and Safety (2-3 periods)	*Secondary Steps* pack. Road Safety - *Why did the chicken cross the road?* Play followed by workshops.

Year 2	*Resources*
Lifeskills & S2 Induction (3 periods) Coping with transitions.	Health Education 13-18- *Lifestyles; Coming of Age.* Lifeskills Teaching Programme 1.
Alcohol Education (10 periods)	Lifelines Book 2. TACADE 11-16 Alcohol Education Pack. Raising the Issues - Alcohol. Cheers or Tears - inc. OHP/slides. Social Education Kit - *Drugs, Drink and Tobacco.* *What Everyone Should Know About Alcohol* - info leaflet. *Drugwise Too.* *The Really Useful Guide to Alcohol* SHEG. Both packs used with all sections.
Social Responsibilities (6 periods) Including Friendship Care of Property Care of People Theft, Consideration, etc	Lifelines Book 2. Active Tutorial Work Book 2. External resource: Visit of Police Officer.
Personal Relationships (5 periods) Assessment of self and others in relationships. In particular - boyfriends and girlfriends.	*Boyfriends & Girlfriends* - Shay McConnan.

Year 3	*Resources*
Alcohol Education (4 periods)	TACADE Alcohol Education - *One of a Crowd;* *Ask Yourself.* *Free to Choose - The Party.* *- Solvent Abuse.*
Scottish Traffic Education Programme (10 periods)	12 packs - Lessons and Videos.
Personal Relationships (5 periods) Family matters	Lifelines Book 2. Getting Personal - *The Family.*

Year 4	*Resources*
Personal Relationships, Health and Welfare (10 periods)	Lifelines Book 4. *AIDS: Take Care Work Pack.* Videos *Your Choice for Life* and *The Truth about Aids.* Leaflet - *Saying No.* *The Three Rs of Family Life* Part 1. *Drugwise - 14-18* pack Scottish Office. *Drugs Leaflets.* School Chaplain - *Why weddings, Why funerals?* - discussion. Young Scot Booklet *The Law and You.* *Make Love Last* - video 1994. Use of ACET materials. HIV - *Facts for Life.*

Year 5	*Resources*
Health Education 1 (4 periods) Alcohol Education	TACADE Alcohol Education - Wider Issues. *Free to Choose.* *Too Much Punch for Judy* - Play and support materials.
Health Education 2 (6 periods) Relationships Stress STD/AIDS	Lifeskills Teaching Programme 1 and 2. Lifelines Book.4. Health Education 13-18 STD Cambridge Fact Sheets. Newspaper cuttings - AIDS. *The Three Rs of Family Life* - Video. First Aid - Pilot group received instruction to certificate level from a Leisure Centre Manager.

Year 6	**Resources**
Life Away From Home (10 periods) Life after school. Living in a new environment. Life in town/city compared with country. Health (looking after your own health - health issues relevant to students - NHS provision and other agencies).	*Leaving Home* - Alan Dearling and Mark Clark. Lifelines Book. 5. *Information About You.*
Life Skills Optional items from S5	Lesson about Drunk Driving - *It Could Happen to You* (video).

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